HIP 2.0

HEALTHY INDIANA PLAN SM

Health Coverage = Peace of Mind

Frequently Asked Questions

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Why HIP 2.0?

1. What is HIP 2.0?

HIP 2.0 is the State of Indiana's plan to improve and expand the successful Healthy Indiana Plan (HIP) and concurrently eliminate traditional Medicaid in Indiana for all non-disabled Hoosiers ages 19-64. HIP currently provides health insurance coverage for uninsured adult Hoosiers ages 19-64 whose household income is at or less than the federal poverty level (FPL) and are who not otherwise eligible for Medicaid. HIP 2.0 builds on the successes of the original HIP design. It adds new pathways for coverage that promote employer-sponsored coverage and continue HIP's private market consumer-directed model with incentives for members to take personal responsibility for their health.

Through HIP 2.0, Indiana will preserve the core principals of HIP while working to:

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

2. Why is Indiana expanding HIP?

Indiana is seeking an expansion of the Healthy Indiana Plan in order to provide insurance coverage options to Indiana's working poor using an innovative, consumer-driven alternative to traditional Medicaid. The Healthy Indiana Plan was passed with bipartisan support in 2007, and in 2011 the General Assembly called for the program to be used as the vehicle for coverage expansion. For more than six years, the Healthy Indiana Plan has delivered quality care to highly satisfied members and achieved measurable results. It has been successful at empowering members to act as consumers in the health care market and to take responsibility for their health care choices. Healthy Indiana Plan members demonstrate higher use of preventive care services and less inappropriate use of the emergency room than traditional Medicaid populations. The Healthy Indiana Plan also ensures access to a robust network of providers by reimbursing providers at Medicare rates.

3. What is consumer-driven health care?

Consumer-driven health care (CDHC) plans pair high deductible health plans with health savings accounts (HSAs) or similar products to pay for initial health care expenses or deductibles. The high-deductible health plan (HDHP) protects them from catastrophic medical expenses, while the deductible exposes them to the costs of their care and engages them to manage their use of services appropriately. The design is referred to as "consumer-driven health care" because basic and routine costs are paid by the patient-managed account versus the insurance company. This promotes consumerism by giving patients greater control over their own health budgets and the health care they receive. The use of CDHPs fosters competition in the marketplace as patients become active consumers and providers compete to provide services, lowering prices and increasing quality.

4. Why is the State using a consumer-driven model?

The State of Indiana has a long history of success with the consumer-driven health care model. The original consumer-driven health care concept was piloted by Hoosier Patrick Rooney who played a key role in winning congressional authorization for HSA accounts in 2003. Perhaps due to its status as a pioneer of the consumer-driven model, Indiana ranks highly among states in consumers covered by high deductible health plans attached to Health Savings Accounts. Studies show that employer adoption of the consumer-driven model considerably decreases total health care spending. Consumer-driven plans are also popular among employees. About 96 percent of Indiana state employees have voluntarily elected to enroll in a consumer-driven health plan option. In its first four years of offering consumer-driven health plan options to state employees, the State has saved 10.7 percent annually, as employees used hospital emergency departments at lower rates, had fewer physician office visits, lower prescription costs and a higher generic medication dispensing rate.

5. What is new in HIP 2.0?

Evaluation and analysis of program data over the first six years revealed areas where HIP could be strengthened to preserve its core principles, while offering new options to members designed to allow access to employer sponsored health plans, promote private family coverage and to assist individuals with employment in order to become more self-sufficient.

HIP 2.0 makes several changes to the original program designed to build on HIP's successes and ensure access to coverage:

- Replaces traditional Medicaid for non-disabled adults ages 19-64 and offers these Hoosiers a choice of HIP plan options.
- Maintains and increases the value of the POWER account for all members. The POWER account is an account that operates similar to a Health Savings Account. Members use this account to pay for their deductible.
- Eliminates enrollment caps in HIP, so that any person under 138 percent of the federal poverty level is eligible for HIP.
- Provides a new option for families to be covered by the same health plan.
- Provides a new HIP Employer Benefit Link plan that supports participation in employer-sponsored insurance plans.
- Institutes new, affordable, required contributions for all members.
- Creates a significant value proposition for Hoosiers below the federal poverty level, rewarding those that contribute to their POWER accounts with access to the "HIP Plus" plan, an enhanced benefit plan that covers dental and vision care.
- Individuals who choose not to make contributions to their POWER accounts will maintain coverage through the HIP Basic plan, a more limited health benefits plan. The HIP Basic plan will provide all essential health benefits, but will offer reduced benefits such as no vision and dental coverage and provides a more limited prescription drug benefit.
- Promotes independence from public assistance by connecting unemployed HIP members with job training and search programs.

6. How much will HIP expansion cost and how will this program be funded?

HIP 2.0 will not raise taxes for Hoosiers. The federal government contributes to the program costs, and the state cost of expanding HIP between 2015 and 2020 is $1.5B. The State cost will be fully funded through Indiana's existing cigarette tax revenue, and through support from Indiana's hospitals, Hoosier taxpayers are further protected by annual contributions into the HIP trust fund to ensure appropriate reserves.

7. What will happen if federal funding is reduced?

The waiver submission is conditioned on the availability of enhanced federal matching funds and the continuation of hospital support for the program. If either funding source is reduced at any point during the five-year waiver period, the HIP 2.0 will automatically terminate for the new expansion population.

8. Does HIP cost more than traditional Medicaid?

HIP's program design bends the cost curve, and the State's actuaries indicate that the cost is lower than a traditional Medicaid expansion.

Who is impacted?

1. **Why is the expansion of HIP needed?**

   Today there are approximately 350,000 low-income uninsured individuals in the state between the ages of 19-64, that do not have access to programs to help them pay for health insurance. Due to the high costs, health insurance is often unaffordable for this population. The State of Indiana proposed HIP 2.0 to help low-income Hoosiers access health insurance coverage without expanding traditional Medicaid. Expanding the Healthy Indiana Plan will alleviate the coverage gap created by the Affordable Care Act (ACA). While individuals between 100 and 400 percent of the federal poverty level can access tax credits to help them pay for health insurance through the new federal Marketplace, individuals below 100 percent FPL (or those earning approximately $11,670 annually for an individual, and $23,850 annually for a family of four) are not eligible for the subsidized private coverage.

2. **Who will be eligible for HIP 2.0?**

   HIP 2.0 will be an option for Hoosiers ages 19 to 64, with incomes up to 138 percent of the federal poverty level (approximately $16,105 annually for an individual or $32,913 for a family of four).

3. **How is the group eligible for HIP 2.0 different than the current HIP program?**

   The current Healthy Indiana Plan (HIP) program targets Hoosier adults between the ages of 19 and 64 with incomes up to 100 percent FPL (approximately $11,670 annually for an individual or $23,850 for a family of four). However, the HIP program has enrollment limits and the current waiver caps the number of adult enrollees without dependents at 36,500 enrollees. HIP 2.0 will be available to *all* adults between the ages of 19 and 64 with incomes up to 138 percent FPL (approximately $16,105 annually for an individual or $32,913 for a family of four). Under HIP 2.0, there will no longer be a cap on the number of Healthy Indiana Plan enrollees.

4. **How many people will be eligible for HIP 2.0?**

   In total, HIP 2.0 will provide a coverage option for an estimated 334,000 to 598,334 Hoosiers who have incomes under 138 percent FPL.

How does HIP 2.0 work?

1. **How does the current Healthy Indiana Plan work?**

   The Healthy Indiana Plan is a public health care assistance program that replicates consumer-driven health insurance options available in Indiana's private insurance market today. HIP offers a Personal Wellness and Responsibility (POWER) account, modeled after a Health Savings Account (HSA), from which members pay for deductible or initial health care expenses. HIP members also receive a high-deductible health plan that offers comprehensive benefits, administered by private insurance companies, that is similar to commercial products offered by employers. There are lifetime and annual benefit limits.

   Members are required to make monthly contributions into the POWER account. The state also contributes to the account to ensure that funding is adequate to cover the deductable or initial health care expenses up to $1,100. Individuals who fail to make monthly contributions are removed from the program for 12 months. Members can roll over any remaining balance in their account to offset required contributions in the following year if they have completed required preventative health care services.

2. **How does HIP 2.0 work?**

   The modifications represented in HIP 2.0 maintain emphasis on the principles of personal responsibility and consumerism. All individuals in HIP will have the opportunity to benefit from receiving recommended preventive services and managing their POWER account funds appropriately. Based on differences in target populations, HIP 2.0 will have slight variations for individuals above and below the federal poverty level. For example, members over the federal poverty level who do not pay a POWER account contribution within 60 days will be disenrolled from the program and locked out from HIP eligibility for six months. Members below the poverty level who do not make their monthly contributions will be automatically transferred to the HIP Basic plan, which offers reduced benefits and may be more costly, as they are subject to copayments for services rather than monthly contributions. Therefore, failure by any HIP 2.0 member to pay a POWER account contribution will likely result in a less rich benefit package at a higher cost than one would receive under the HIP Plus plan.

3. **Will HIP 2.0 still have POWER accounts?**

   HIP 2.0 maintains and strengthens the POWER account for all participants, with changes to enhance the impact and to give Hoosiers more control over their health care decisions. Both the POWER account and plan deductible will increase from $1,100 to $2,500 to better align with deductibles typical in commercial market high deductible health plans.

However, this increase will result from increased contributions by the state and will have no impact on member contributions. HIP 2.0 participants who choose the new HIP Employer Benefit Link option will gain access to a defined contribution POWER account from which they can pay for any cost sharing required by their employer-sponsored insurance plan.

With this increased account limit, members will have more dollars to manage and will experience more exposure to the costs of health services. Exposure to and awareness of the cost of care are key components of the consumer-directed model that encourages price and quality transparency from providers. The increased deductible aligns with private market high deductible health plans paired with a health savings account, providing members valuable experience with a private market plan design.

4. **Will participants have to pay more since the account is increasing?**

No. The State will fund the account with the difference between the deductible and the member's annual contributions. HIP 2.0 creates new required flat contribution amounts designed to be affordable for all members.

5. **What are the new contribution amounts?**

FPL	Monthly Income Single Individual	Monthly Contribution
<22%	$214	$3
23 -50%	$224 to $487	$8
51 -100%	$496 to $973	$15
101 -138%	$983 to $1,342	$25

6. **Are there other costs members will have?**

As long as members makes their required POWER account contributions, they will have no other costs, except for a copayment of up to $25 for non-emergency use of the hospital emergency room. However, this copayment will be waived if the member contacts the 24 hour nurse's hotline for prior authorization before visiting a hospital emergency department.

7. **Can the member receive help paying for their required contribution?**

HIP 2.0 will retain the current HIP program policies allowing employers to contribute up to 50 percent of the individual's required monthly contribution and non-profit

organizations to contribute up to 75 percent of the individual's required monthly contribution. In addition, the health plans may implement a rewards program that allows members to "earn" additional dollars in their POWER account (up to 50 percent of the individual's required monthly contribution) for completion of specified healthy behaviors, such as completing a smoking cessation program.

8. What happens to individuals who do not make contributions into their POWER account?

HIP is a proven health coverage model designed around the promotion of personal responsibility. Data show that individuals who make POWER account contributions utilize care more efficiently with fewer emergency room visits and more preventive care services. The penalties associated with non-payment of a monthly POWER account contribution vary depending on the individuals' income level.

- Individuals below the federal poverty level that do not make subsequent contributions are moved to the HIP Basic plan, where copayments are required for all services, and they will have a reduced benefits package.

- Consistent with federal Marketplace policies, individuals above the federal poverty level that do not make contributions are disenrolled from HIP and must wait six months to re-enroll.

9. What are the copayments under the Basic Plan?

The HIP Basic plan will charge the following copayments for all health care services, except preventive care and family planning services, which will be exempt from the copayment requirements. Members only pay the following copayments if they elect not to make POWER account contributions and default into the HIP Basic plan from the HIP Plus plan.

Service	Basic Plan Co-Pay Amounts <=100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

10. What is the difference in rollover between HIP Basic and HIP Plus?

Members in the HIP Plus plan are eligible to reduce their future annual contributions regardless of whether they receive their recommended preventive care. Provided that the remaining POWER account balance is the same, HIP Plus members who receive preventive care will receive twice the reduction in their future annual contribution as those that do not receive preventive care. Members in the HIP Basic plan are only eligible to reduce their required annual contributions if they receive preventive care and they can only reduce their required contribution by half.

The HIP Basic plan does not include coverage for vision services, dental services, bariatric surgery or temporomandibular joint (TMJ) treatment. HIP Basic also contains greater restrictions on prescription medications and limits on other services.

The HIP Plus plan provides the "best deal" for members. They can make upfront payments that amount to, on average, less than 2 percent of their income. The HIP Basic plan requires copayments for all services, and the total amount will be unpredictable.

11. What is the HIP Plus plan?

The HIP Plus plan is a comprehensive benefit package that is available to all HIP members that make their POWER account contributions. Members in the HIP Plus plan will have no other cost-sharing in addition to their monthly POWER account contribution, except for a copayment for improper (non-emergency) use of the hospital emergency room.

12. Who is eligible for the HIP Plus plan?

The HIP Plus plan will be the default plan, and will be available to all HIP members with income under 138 percent FPL who are successful in making their required monthly POWER account contributions.

13. What benefits does the HIP Plus plan have?

The HIP Plus plan includes comprehensive commercial market coverage for all of the essential health benefits, including maternity services. The plan offers additional enhanced coverage beyond the required essential health benefits, including vision and dental services and bariatric surgery for adults. In addition, the HIP Plus plan includes a comprehensive prescription drug benefit.

14. How do the HIP Plus benefits vary from HIP's current benefits?

The current HIP benefits do not include coverage for maternity services, adult dental or vision, all of which are provided under HIP Plus. Some HIP Plus services will also have increased service limits from the current HIP program, including an increased limit on the number of days of skilled nursing facility coverage. The lifetime and annual benefits limits have also been removed.

15. What is the HIP Basic plan?

The HIP Basic plan is a complete commercial market benefit package that offers coverage for all of the essential health benefits but does not have benefits as rich as the HIP Plus plan. Members in the HIP Basic plan are defaulted into the plan because they do not pay POWER account contributions. The HIP Basic plan will require copayments for all services, except preventive care and family planning services.

16. Why do people enrolled in the HIP Basic plan get different benefits?

Healthy Indiana Plan program results show that members who make POWER account contributions use health services more consciously and make fewer trips to the emergency room while using more primary care services compared to members who do not contribute to their POWER account. Contributing to the POWER account will offer members additional incentives to make this important investment in their health. While the basic plan offers essential health benefits for individuals that do not make POWER account contributions, it does not offer enhanced benefits such as vision and dental. This will incent individuals to make contributions into their POWER account.

17. Who is eligible for the Basic plan?

As an alternative to disenrollment, the HIP Basic plan is only offered to individuals with incomes below the federal poverty level who do not make their POWER account contributions under the HIP Plus plan. Since the members in the HIP Basic plan do not make POWER account contributions, they must make copayments for all services. Individuals with income between 100 percent FPL and 138 percent FPL are not eligible for HIP Basic plan coverage and must make required POWER account contributions to remain eligible for HIP 2.0.

18. What happens to the POWER account in the Basic Plan?

Members in the HIP Basic plan will still use the POWER account to cover their $2,500 annual deductible, but the funds in the account will be contributed entirely by the State. HIP Basic plan members will still receive POWER account statements to assist them in managing the account and to increase their awareness of the cost of the health care services they receive.

19. Does the HIP Basic plan POWER account still have incentives for preventive care and to manage the account?

Yes. Similar to the current HIP structure, every member will be eligible to reduce future POWER account contributions for the following year if they receive recommended preventive care services and manage their POWER account judiciously.

20. How will HIP 2.0 impact individuals with access to employer-sponsored insurance?

Starting in 2016, HIP 2.0 will provide new choices for HIP members with access to employer-sponsored insurance through a new program called HIP Employer Benefit Link. HIP eligible individuals may choose to either enroll in HIP or to receive a defined contribution from the State which they can use to pay for their employer-sponsored premiums and other cost sharing.

21. Do individuals with access to employer-sponsored health insurance have to use their employer's plan?

No. Enrollment in the employer-sponsored coverage is not mandatory, and eligible individuals will be given the option to choose based on which plan is best for their individual health care needs. All HIP-eligible adults with access to employer-sponsored insurance will receive options counseling through an enrollment broker regarding whether enrollment in HIP or their employer plan would be best suited to their individual needs and situation.

22. Do individuals that choose to enroll in employer-sponsored insurance still have a POWER account?

Yes. Individuals who choose to enroll in employer-sponsored insurance will still have a POWER account and will be required to make monthly contributions. The State will provide a defined contribution to the POWER account that can be used to cover the cost of the individual's premium and to pay for any required cost sharing under the employer plan, including the deductible and copayments.

The State will fund the POWER account to the average amount that an individual covered by an employer-sponsored plan may be expected to spend for premium and other out-of-pocket expenses.

23. What happens if individuals with premium assistance for employer-sponsored insurance do not pay their POWER account contribution?

Individuals who choose to participate in the HIP Employer Benefit Link program for employer-sponsored insurance will have $50 deducted from their POWER account balances for each missed contribution.

24. Will HIP Employer Benefit Link support offer the option for family coverage?

Yes. Individuals eligible for HIP 2.0 with access to employer-sponsored insurance may choose premium support for their entire family. In addition, families with incomes above 138 percent FPL with Hoosier Healthwise-eligible children may also use this option to enroll these children in their Marketplace plan.

25. How will the family premium support option work?

Under HIP 2.0, all eligible individuals' ages 19 to 64 in the family may enroll in either HIP Plus or HIP Employer Benefit Link. Children under age 19 would currently be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). However, beginning in 2016, the family would have the option to enroll these children in either the participant's employer-sponsored coverage through HIP Employer Benefit Link or the participant's Marketplace plan.

26. How will the POWER account work for family employer-sponsored coverage?

Families enrolled in HIP Employer Benefit Link will receive an increased defined contribution POWER account from the State to cover the additional premium and cost sharing expenses of having more than one adult enrolled in the employer-sponsored insurance.

POWER account contributions will be required from every HIP eligible adult enrolled in HIP Employer Benefit Link, and these contributions will accrue to one family POWER account.

27. Can families use the POWER account to pay for the out of pocket expenses for their children?

No. The POWER account is only intended to cover the premium for employer-sponsored coverage and the out of pocket expenses for adults over 21 enrolled in HIP Employer Benefit Link. Children under 19 will receive supplemental Medicaid coverage for cost-sharing on the employer-sponsored plan and for benefits not covered by the employer's plan.

28. Why are maternity services now available in HIP 2.0?

Maternity services are being added to the HIP 2.0 benefit package to allow women who become pregnant while covered by HIP to stay with their plan and provider network. Pregnant women will be exempt from all HIP cost-sharing for the duration of their pregnancy, and will receive all of the same benefits they would receive if their coverage changed from HIP to traditional pregnancy Medicaid coverage, including non-emergency medical transportation.

What's next?

1. How does the waiver approval process begin?

There will be a 30-day formal public notice and comment period during which the public can review the waiver and submit comments to the State. During this time, a draft of the waiver and other related documents will be posted on the Healthy Indiana Plan website at www.HIP.in.gov. In addition, during the public comment period, the State will conduct two separate formal public hearings that can be attended in person or by phone or webcast. The dates and times are as follows:

- May 28, 2014, at 9:00 a.m. at the Indiana Government Center South, Conference Center Room B, located at 302 West Washington Street in Indianapolis
- May 29, 2014, at 1:00 p.m. at the Indiana Statehouse, Room 156-B, located at 200 West Washington Street in Indianapolis. Public entrances to the Statehouse are located on the east and west sides of the building.

Top officials from Governor Pence's administration will also conduct town hall meetings at locations throughout the state to discuss HIP 2.0 and educate Hoosiers on the design of the plan prior to finalizing the waiver submission in late June.

To comment on the HIP 2.0 waiver, the email address is HIP2.0@fssa.IN.gov. To comment on the contingent waiver to continue the current HIP program, the email address is HIP.Renewal@fssa.IN.gov.

2. Why is the State submitting two waivers?

In the event that the federal government does not approve HIP 2.0, the State has submitted an alternative waiver to continue the current HIP program in its existing format in order to ensure the continuation of health coverage for the program's current members.

The 1115 demonstration request for HIP 2.0 extends HIP coverage to all eligible adults ages 19-64 with income less than 138 percent of the federal poverty level and implements some new options for participants. The HIP extension waiver continues the current HIP program with no changes and HIP would only be available to adults with income up to 100 percent FPL.

3. When will HIP 2.0 begin?

HIP 2.0 is contingent upon the approval of the State's waiver by the federal Centers for Medicare and Medicaid Services and approval of a final financing plan by the state budget committee. The State's goal is to secure these necessary approvals and begin HIP 2.0 enrollment in 2015.

4. When will the HIP Employer Benefit Link premium assistance option be available?

The State intends to offer the premium assistance program for both HIP eligible adults and Hoosier Healthwise eligible children beginning in 2016.