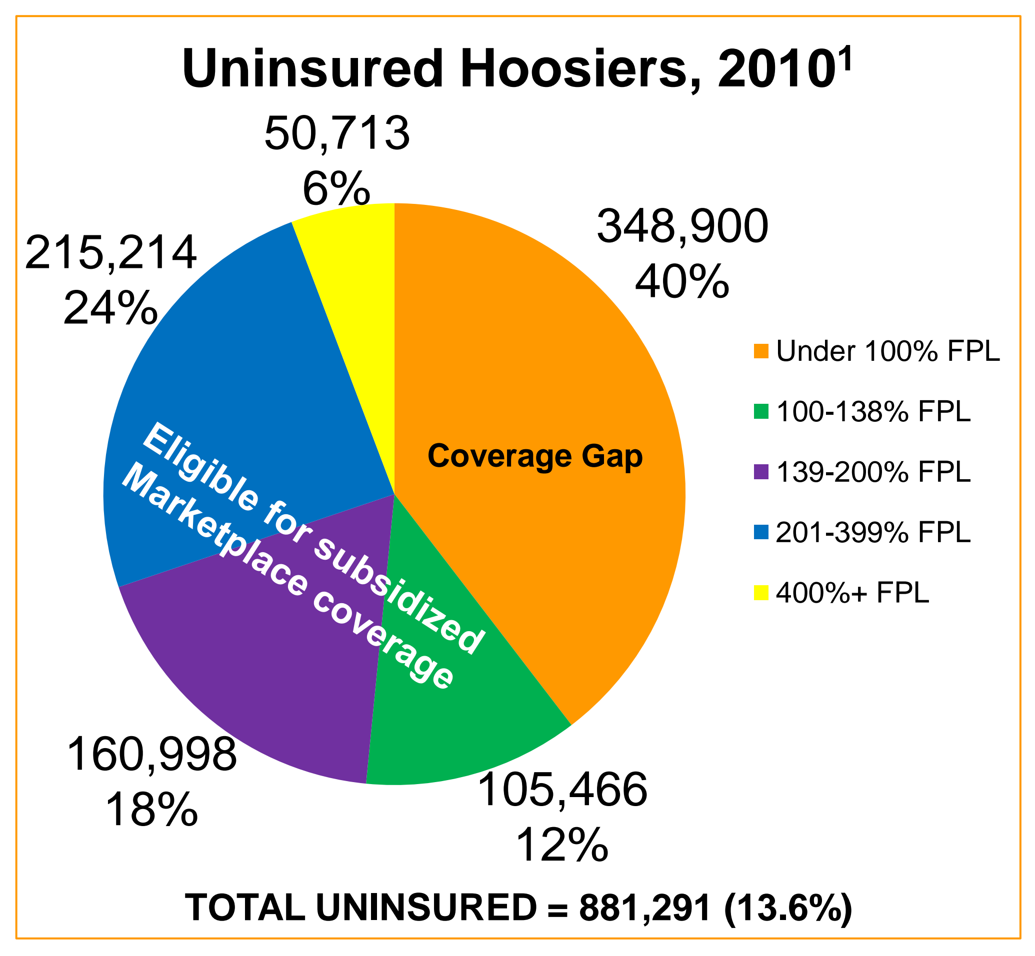
HIP 2.0 APPROVED!

Overview Presentation
February 16, 2015

State of the Uninsured in Indiana



1. SHADAC Health Insurance Analysis. (2011). American Community Survey data. Retrieved from www.nationalhealthcare.in.gov.

Healthy Indiana Plan

- ✓ True Medicaid Reform
- ✓ First Medicaid plan with strong consumer-directed features (2008)
  - HDHP
  - POWER Account
  - Consumer choice + Provider engagement
- ✓ Proven Results
- ✓ High Member and Provider Satisfaction
  - Enhanced coverage
  - Enhanced provider reimbursement

Why is Indiana using a consumer-directed model?

- ✓ The State of Indiana has a long history of success with the consumer-directed health care 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-directed model considerably decreases total health care spending.
- ✓ Consumer-directed plans are also popular among employees.
- ✓ Consumer-directed plans lower unnecessary healthcare

HIP Success

HIP improves health care utilization

- Lowers inappropriate emergency room use by 7% compared to traditional Medicaid
- 60% of HIP members receive preventive care - similar to commercial populations
- 80% of HIP members choose generic drugs, compared to 65% of commercial populations

HIP results in high member satisfaction

- 96% of enrollees satisfied with HIP coverage
- 83% of HIP enrollees prefer the HIP design to co-payments in traditional Medicaid
- 98% would enroll again

HIP promotes personal responsibility

- 93% of members make required POWER account contributions on time
- 30% of members ask their healthcare provider about the cost of services

Medicaid Reimbursement Rate Increases

- In Medicaid (Hoosier Healthwise/pregnancy/kids and aged, blind and disabled)
  - **INCREASED rates by an average of 25 percent**
    - **Behavorial Health= 85% of Medicare**
    - **Prenatal/Maternity = 100% of Medicare**

Medicare Reimbursement Rates

HIP Reimbursement Rates

- Medicare Rates
- 130% of Medicaid rate if no Medicare rate exists

Different Process for Conversion Populations

- Inpatient claims for Low Income Parents, Caretakers and 19 and 20 year olds are reimbursed at the Hoosier Healthwise rate, and then HAF adjustment will be made later.

Maintaining Financial Sustainability

HIP 2.0 will be sustainable & will not increase taxes for Hoosiers

HIP 2.0 will continue to utilize HIP Trust Fund dollars

HAF - Indiana hospitals will help support costs to expand HIP 2.0 starting in 2017

Waiver specifies HIP 2.0 continuity requires:

-Enhanced federal funding

-Hospital assessment program approval

HIP 2.0: Basics

Who is eligible for HIP 2.0?

- Indiana residents
- Age 19 to 64
- Income **under 138%** of the federal poverty level **(FPL)**
- Not eligible for Medicare or other Medicaid categories
- Also includes all non-disabled adults currently enrolled in Medicaid

Monthly Income Limits for HIP 2.0 Plans 2014 FPL

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

HIP 2.0: Closing the Coverage Gap

*Maternity services are added to HIP 2.0, so pregnant women may choose to stay in HIP
FPL is recalibrated annually and dependent on household size. In 2014, the FPL (100%) for a family of four is $23,850 of annual income.

HIP 2.0 Plan Structure

Essential Health Benefits
- Enhanced benefits in HIP Plus
- Minimum Essential Coverage in HIP Basic

POWER Account

$2,500 account
Holds State and Member contributions
Covers initial health expenses*

Preventive Care
Provided outside of POWER account.

Covered Services
- Comprehensive essential health benefits
- Maternity benefits provided
- Enhanced benefits for HIP Plus members including vision and dental benefits
- Benefits meeting all minimum requirements for HIP Basic members
- No annual or lifetime dollar limits

*Covered benefits beyond $2,500 paid by member's health plan

HIP 2.0: Plan Options

Best Value

HIP Plus

- Initial plan selection for all members
- **Benefits**: Enhanced benefits: vision, dental, bariatric, pharmacy
- **Cost sharing**:
  - Monthly POWER account contribution required. Contribution is 2% of income with a minimum of $1 per month.
  - Employers & not-for-profits may pay up to 100% of member contributions
  - ER copayments only

HIP Basic

- Fall-back for members <100% FPL that do not make POWER account contribution
- **Benefits**: Minimum coverage, **no vision or dental coverage**
- **Cost sharing**:
  - Must pay copayment ranging from $4 to $75 for doctor visits, hospital stays, and prescriptions

HIP Link

- ***More information coming soon!***
- Enhanced POWER account to pay for premiums, deductibles and copays in employer sponsored plans
- Provider reimbursement at commercial rates

HIP Plus: POWER Account Contribution (PAC)

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

Maximum Monthly HIP 2.0 POWER account contributions (PAC)

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

*Amounts can be reduced by other Medicaid or CHIP premium costs

**To receive the split contribution for spouses, both spouses must be enrolled in HIP

Ways to Pay the POWER Account Contribution

HiP 2.0 HEALTHY INDIANA PLAN℠ Health Coverage = Peace of Mind

✓ Regardless of health plan, members can pay by:
- Credit or debit card (including prepaid cards)
  - Over the phone
  - Online
- Check or money order
- Automatic bank draft
- Electronic funds transfer
- Payroll deduction
- Cash, at one of the following locations:

Anthem	MHS	MDwise
Pay at any Wal-Mart	Pay by Western Union *Coming soon:* Pay at any Wal-Mart	Pay at a Fifth Third Bank *Coming soon:* Pay at any Wal-Mart

Non-Payment Penalties

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

≤100% FPL

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

>100% FPL

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

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

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

HIP Plus

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

HIP Basic

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

POWER Account: Incentives for Completing Preventive Care

HIP Plus POWER account

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

Year-End Account Balance

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

HIP Basic POWER account

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

Year-End Account Balance

- If preventative services completed, members can offset required contribution for HIP Plus by up to 50% the following year
- **Example**: Member receives preventive services and has 40% of original account balance remaining at year end. May choose to move to HIP Plus the following year and receive a 40% discount on the required contribution.

HIP 2.0: Treatment of Unique Populations

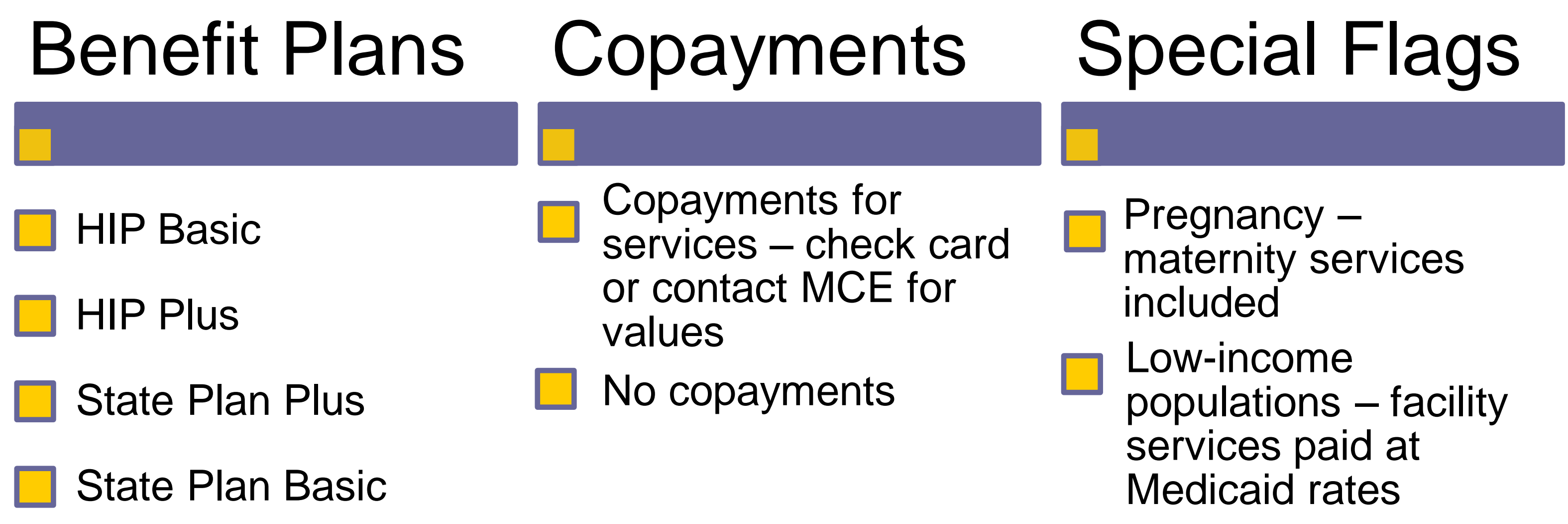
Medically Frail	Individuals with a disability determination, certain conditions impacting their physical or mental health or their ability to perform activities of daily living such as dressing or bathing will receive enhanced benefits • HIP Basic or HIP Plus cost sharing will apply but access to vision,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

HIP 2.0: State Plan

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

Eligibility Verification

- ✓ You will still be able to verify member eligibility via normal processes
- ✓ Verification will indicate member's benefit plan and cost sharing responsibility



Cost Sharing

- HIP Basic members required to pay copayment for services[1, 2]
- Provider verifies if member must pay copayment when checking eligibility
- Provider should collect all copayments at time of service[3]
- Payment to provider will be reduced by amount of copayment

1. Member does not pay copayment after 5% of household income spent on out-of-pocket health care costs
2. Pregnant women and Native Americans exempt from cost sharing
3. Provider cannot deny service based on member inability to pay

HIP Basic Plan: Cost Sharing

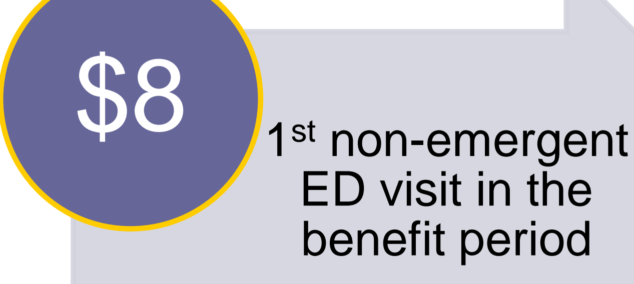
When members with income less than or equal to 100% FPL do not pay their HIP Plus monthly contribution, they are moved to HIP Basic. HIP Basic members are responsible for the following copayments for health and pharmacy services.

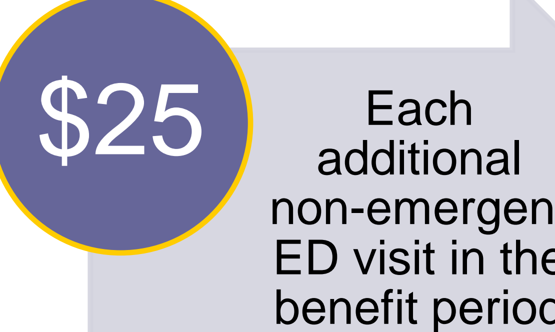
Service	HIP Basic Copay Amounts Income ≤100% FPL
Outpatient Services	$4
Inpatient Services	$75
Preferred Drugs	$4
Non-preferred drugs	$8
Non-emergency ER visit	Up to $25

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

Emergency Department (ED) Copayment Collection

- ✓ HIP requires non-emergent ED copayments unless:
  - Member meets cost sharing maximum for the quarter
  - Member calls MCE Nurse-line and is told to go to ED
  - The visit is a true emergency
- ✓ HIP features a graduated ED copayment model
  - Providers should call the MCE to determine the member's copayment at each non-emergent ED visit





The Medically Frail

What is Medically frail?

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

What conditions make someone “medically frail?”

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

Medically Frail: Benefits and Cost Sharing

What benefits do medically frail receive?

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

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

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

Medically Frail Identification

At application:
Member indicates medically frail on frail screening questions

Annually after frail verification:
MCE verifies medically frail status in claims

After enrollment:
- Member notifies MCE* of medically frail status
- MCE confirms using claims, lab results, etc.

Identification of medically frail individuals

<u>Provider Impact</u>:

- **Information request from managed care entity (MCE)**:
  - MCE verifying member medically frail status
- **Eligibility verification provides information for**:
  - Member medically frail status & access to HIP State Plan benefits

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

Pregnancy Determination

HIP member tells MCE she is pregnant

(self-attestation)

HIP member tells Division of Family Resources she is pregnant

(self-attestation)

MCE review of claims data indicates pregnancy

HIP learns a member is pregnant

HIP Coverage for Pregnant Women

Woman becomes pregnant while enrolled in HIP

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

Woman is pregnant at application or redetermination

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

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

Pregnancy Benefits

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

Additional Benefits Include:
Vision
Dental
Non-emergency transportation

Pregnancy Benefits, cont.

How long will maternity services be covered?

- Up to two months (60 days) post-partum
  - Woman must report end of pregnancy BEFORE end of 60 day post-partum period to avoid coverage gap

How will member costs change for pregnant women?

- There is no cost sharing for pregnant women
- POWER account is frozen during pregnancy/post-partum period
- No cost sharing for HIP 2.0 or HIP Maternity (MAGP) during pregnancy/post-partum period

How will health care provider know maternity benefits status?

- Eligibility verification will show provider:
  - Maternity benefits coverage
  - No cost sharing obligation

Application Features: Gateway to Work

HIP 2.0 applicants and members referred to existing State workforce training programs and job search resources if:

- ✓ Unemployed or working less than 20 hours per week **AND**
- ✓ Not full-time students

Notes:
SNAP recipients who have already been sent to Gateway to Work will not be referred again

Not participating in the Gateway to Work program does not impact HIP 2.0 eligibility

HIP Employer Benefit Link
COMING SOON!

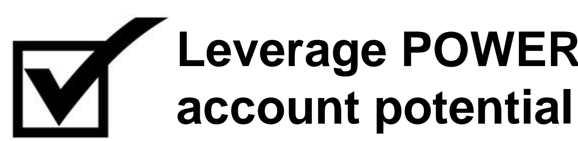
✓ NEW EMPLOYER PLAN OPTION

- Families can choose to enroll in employer-sponsored health insurance
- Employer must sign up and contribute 50% of member's premium

✓ POWER ACCOUNT

- Member makes contributions to POWER account
- *Defined contribution* from State to allow individuals to
  - Pay for employer plan premiums &
  - Defray out-of-pocket expenses

Promote family coverage in private market



Applying for HIP 2.0: Application Methods

Indiana Application for Health Coverage

Estimate eligibility and POWER account contribution amounts with the **online calculator** at:

http://www.in.gov/fssa/hip/2352.htm

Best Option

Apply for HIP by completing:

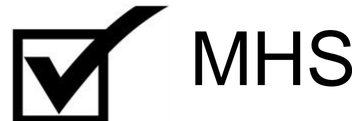
1. **Online Health Coverage Application available at:** **https://www.ifcem.com/CitizenPortal/application.do#**
2. Phone Application
3. Paper Application

Single application for all coverage programs

Find a local navigator to help with enrollment at: http://www.in.gov/healthcarereform/2468.htm

Application Features: Selecting a Managed Care Entity

- ✓ Indiana Application for Health Coverage will offer choice of three managed care entities (MCE) and applicants choose:



- ✓ Selecting a MCE
  - Doctors and hospitals may vary by MCE
    - RECOMMEND: Ask preferred doctor(s) to ensure MCE coverage
  - Selection assistance available from MAXIMUS
    - 1-877-GET-HIP-9 (1-877-438-4479)
    - Able to answer questions about MCEs
  - If no selection made, MCE will be auto-assigned

Selecting a Managed Care Entity

Select or auto-assign managed care entity (MCE)

Member can change MCE any time before paying POWER account contribution (PAC)	Decision to change MCE does not provide additional time to make PAC

Pay POWER account contribution (PAC) to MCE

If PAC made to incorrect MCE, may correct, but must do so within 60 day time limit

FAST TRACK Payment Coming Soon

HIP 2.0 coverage begins

When Individuals Can Change Managed Care Entity (MCE)

✓ Individuals may change MCE:

At determination

- **After** assessed eligible for HIP
- **Before** paying POWER accou

When just cause

- **After** PAC paid
- Just cause reasons include (but are not limited to):
  - Lack access to medically necessary covered services
  - Lack access to providers experienced in dealing with member health care needs
  - Poor quality of care, including failure to comply with established standards of medical care

At redetermination

- **After** reassessed eligible for HIP
- **Before** paying PAC

For more information about changing MCE, contact 1-877-GET-HIP-9 (1-877-438-4479)

HIP Plus Enrollment

Applicant determined eligible for HIP 2.0

Applicant receives bill from selected / auto-assigned managed care entity (MCE)

Considered a *conditional HIP member*

60 days to pay POWER account contribution (PAC) to MCE

Conditional member pays first PAC to MCE

Enrolled in HIP Plus

HIP Plus benefits begin the month of first payment

No Retroactive Coverage

- ✓ HIP 2.0 does not provide coverage for:
  - The months before the initial POWER account contribution is (PAC) paid *or*
  - The months prior to when an individual defaults into HIP Basic
- ✓ Encourages Individuals to Maintain Insurance

HIP Basic Enrollment

- ✓ HIP Basic available for individuals:
  - With income less than or equal to 100% FPL **AND**
  - Who do not make the HIP Plus required contribution within 60 days
    - May not call and ask to be enrolled in HIP Basic prior to the end of the 60 day payment period
- ✓ HIP Basic coverage:
  - Effective the 1st of the month in which the 60 day invoice payment period ends
- ✓ EXAMPLE:

2/1/2015
Individual with income less than or equal to 100% FPL applies for Indiana Health Coverage programs

3/15/2015
Individual qualifies for HIP 2.0
Receives bill from managed care entity

5/15/2015
POWER account contribution payment period ends
Individual moved to HIP Basic

5/1/2015
HIP Basic benefits begin

Moving to HIP Plus

- ✓ Members may move from HIP Basic to HIP Plus
  - During annual redetermination
  - During POWER account rollover period

Enrollment for Individuals with Income Greater than 100% FPL

✓ Access to HIP Plus

- Make POWER account contributions (PACs) to enroll and remain enrolled
- No benefits received until the first of the month the initial payment made
- If no payment is made in 60 days, then individuals needs to reapply in order to receive coverage

Dis-enrolling from HIP 2.0

- ✓ Common reasons individuals dis-enroll from HIP
  - No longer eligible for HIP
    - Became eligible for Medicare
    - Became eligible for other Medicaid category
      - E.g. Disability, Aged, Pregnant, etc.
    - Income increased to over 138% FPL
    - Moved out of state
    - Failed to complete redetermination
  - HIP Plus members who do not pay monthly POWER account contribution within 60 days
    - Members with income less than or equal to 100% FPL automatically enrolled in HIP Basic
    - Members with income greater than100% FPL dis-enrolled from HIP and subject to a 6 month lockout period
      - **Exceptions**: Native Americans, Transitional Medical Assistance, Medically Frail, Pregnant women, Individuals living in a domestic violence shelter, Individuals in a state-declared disaster area

Dis-enrolling from HIP 2.0 (cont.)

- ✓ POWER account contributions after dis-enrolling
  - Members leaving the program early may receive a refund for any unused contribution
    - Reporting a change that makes them ineligible for HIP (e.g. move to a different state): 100% of remaining member contribution
    - For non-payment of POWER account contribution: Amount will be reduced by 25%

Lockout Periods

- ✓ Medicaid eligibility during lockout periods
  - Individuals who submit a new application during their HIP lockout period will have their eligibility considered for Medicaid categories, but will not be eligible for HIP
- ✓ HIP Members are subject to a 6 month lockout period* if:
  - They were HIP Plus members receiving benefits **AND**
  - Have income greater than 100% FPL and less than ~138% FPL **AND**
  - Failed to make POWER account contribution
    - Members have 60 days after the due date to pay POWER account contribution before being locked out of the program
    - If locked out, application data forwarded to the federal Health Insurance Marketplace
  - **OR** they fail to submit their redetermination paperwork on time

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

HIP 2.0 Coverage

When does service coverage begin?

- February 1, 2015
- HIP & applicable HHW members converted to HIP 2.0 without having to reapply
- New applicants may submit Indiana health coverage application and be considered for HIP coverage

What types of services are covered?

- HIP Basic:
  - Minimum Essential Coverage providing the Essential Health Benefits
- HIP Plus:
  - HIP Basic benefits with additional services including bariatric surgery, TMJ treatment, and more allowed physical, speech and occupation therapy visits
  - **Vision**
  - **Dental**

Transition to HIP 2.0

Who provides services to HIP 2.0 members?

- Eligible Providers must enroll as Indiana Health Care Provider with Indiana Medicaid and…
- Must enroll with Managed Care Entity (MCE) to provide in-network services to HIP members
- All HIP members will have a Primary Medical Provider (PMPs)

Who pays for services?

- **Risk-based MCEs**
  - Anthem
  - MDWise
  - Managed Health Services (MHS)

*Does not include emergency service providers

Transition to HIP 2.0

How will members be placed in a MCE?

- **Current members will stay with current MCE**
- **New members select MCE**
  - On application **OR**
  - Call enrollment broker after application **OR**
  - Auto-assigned by HP

How should one answer member questions?

- Refer members to their MCE
  - Anthem: (866) 408-6131
  - MDWise: (800) 356-1204
  - MHS: (877) 647-4848

*Does not include emergency service providers

Individuals currently enrolled in the Federal Marketplace

HIP eligible individuals currently enrolled in Marketplace coverage need to transfer to HIP

Will owe back premium tax credit if they do not transfer

These individuals have received instructions on how to update their Marketplace account

Updating the Marketplace account will route the individuals information for consideration for HIP

Once individuals receive confirmation of their HIP coverage start date they should cancel their Marketplace plan

Activity so far...

- ✓ In the first two weeks since Governor Pence announced HIP 2.0:
  - Approx. 180,000 immediately enrolled in HIP 2.0
  - Approx. 39,000 applications for health coverage submitted (33,000+ online)
  - 24,150 phone calls received
  - 24,000 notices sent to Marketplace members

Help us get the word out!

- ✓ HIP.IN.gov is your primary resource
  - About HIP
  - Am I Eligible? Includes eligibility and income calculator
  - How to Enroll?
  - Provider links – health plans, pharmacy
  - Helpful Tools (to download)
    - Brochures, articles, graphics, training slides
- ✓ 1-877-GET-HIP-9
- ✓ Advertising campaign to come
- ✓ Events statewide being scheduled

Questions?