Summary of Indiana's Alternative Medicaid Expansion:
Healthy Indiana Plan 2.0

Background and Overview

On May 15, 2014, Governor Mike Pence announced his Plan to expand Medicaid in the State of Indiana to approximately 350,000 Hoosiers through a new program entitled the Healthy Indiana Plan (HIP) 2.0. The proposed program, which requires federal Section 1115 waiver approval, builds upon and reforms the State's current HIP program, which began providing insurance to a limited number of Indiana Medicaid beneficiaries in 2007.

HIP 2.0 will be available to newly Medicaid-eligible, non-disabled adult individuals ages 19 to 64 with incomes up to 133% of the federal poverty level (FPL). HIP 2.0 includes two different coverage programs – HIP Plus and HIP Basic – that meet the Affordable Care Act's (ACA) minimum coverage requirements with one option, HIP Plus, offering a more comprehensive benefits package. The HIP Plus Plan will be utilized by all beneficiaries above 100% FPL and will be optional for Plan members below 100% FPL. HIP 2.0 will also include another program, HIP Employer Benefit Link, which will provide financial assistance to beneficiaries who purchase employer-sponsored health insurance.

The State will update its current HIP benefits to meet Alternative Benefit Plan requirements and is seeking a waiver of the requirement to provide non-emergency transportation for most able-bodied individuals. As opposed to the current HIP program, HIP 2.0 does not include an enrollment cap or annual and lifetime coverage limits. The Pence administration believes HIP 2.0 will incentivize individuals to take more responsibility for their health care choices by requiring HIP 2.0 beneficiaries to contribute to the cost of their health care through monthly contributions to a type of health savings account, known as a Personal Wellness and Responsibility (POWER) account, and/or co-payments for certain services not to exceed 5% of annual family income. The State is also proposing a Gateway to Work program that requires all HIP 2.0 non-disabled adult participants who are unemployed or working less than 20 hours per week to be referred to the State's workforce training and work search programs.

The State submitted its HIP 2.0 waiver, which amends and renews the current HIP program, for approval to the Centers for Medicare and Medicaid Services (CMS) on July 2, 2014. The State also submitted a three-year waiver extension proposal for it's current HIP program should CMS not approve of their HIP 2.0 waiver or make substantial alterations that, in the State's view, would compromise it's proposal's intent. The State hopes to receive federal approval and to begin HIP 2.0 enrollment in 2015.

HIP Plus Plan

The HIP Plus Plan will be available to all Hoosiers with incomes below 133% FPL who make their monthly POWER account contributions. Beneficiaries, whose contributions will be based on a sliding income scale, and the State will fund the POWER account. No other contributions or cost-sharing, except for non-emergent use of the emergency room, will be required of HIP Plus beneficiaries. Benefits will include comprehensive medical coverage as well as dental, vision, and maternity services with no additional cost-sharing for the duration of the pregnancy. The Plan also provides a comprehensive prescription drug benefit to its members. If an individual with income above 100% FPL fails to make a monthly POWER account contribution, the individual will be disenrolled from the program for six months following a 60-day grace period. If an individual with income below 100% FPL fails to make their monthly POWER account contribution, they will be transferred to the HIP Basic Plan and will be required to make co-payments for many services.

HIP Basic Plan

The HIP Basic Plan will be available to all Hoosiers with incomes below 100% FPL who choose not to meet the requirements for participation in the HIP Plus Plan. HIP Basic includes a limited benefit package, excluding both vision and dental benefits. Hip Basic Plan beneficiaries will not be required to make monthly contributions to their POWER accounts, but will be required to make co-payments for all services provided, except for preventative care and family planning services. HIP Basic will also provide maternity services with no additional cost-sharing and will have a more limited prescription drug formulary and lower service limits. Proposed co-payments include $4 for outpatient services, $75 for inpatient services, $4 for preferred drugs, $8 for non-preferred drugs, and up to $25 for non-emergent use of the emergency room.

HIP Employer Benefit Link

The optional HIP Employer Benefit Link will provide financial support to all HIP eligible individuals with access to or who wish to access cost-effective employer-sponsored insurance. Employee Benefit Link participants can use their POWER accounts to pay premiums, co-payments, or deductibles. Both the individual and the State will make monthly contributions to the POWER account. According to the State's proposed waiver, the State hopes to offer an optional premium assistance program for children currently receiving benefits through the Children's Health Insurance Program, whereby the State will provide premium assistance to allow these children to receive services under their parent's employer-sponsored or Marketplace Plan. The State will implement this Plan in 2016, the second year of the demonstration.

State Plan Benefits

Individuals who are medically frail, very low-income parents, and pregnant women will be enrolled in HIP 2.0 but will receive benefits equivalent to coverage on the State Plan. Individuals in the State Plan may choose between co-payments or POWER account contributions, except for pregnant women, who are exempt from any cost-sharing.

Cost-Sharing

The State uses two forms of cost sharing in HIP 2.0: POWER account contributions and co-payments. POWER accounts will be prefunded by the State minus the member's required total annual contribution. Under the proposed waiver, the State is increasing the total of the POWER account from $1,100 to $2,500. Monthly POWER account contributions for enrollees will be tiered based on income, with a maximum of $25 per month for individuals with incomes over 100% FPL, an amount intended to align with premiums charged by Qualified Health Plans in the Marketplace. For HIP 2.0 members above 100% FPL, monthly payments are required to maintain eligibility. HIP Basic Plan members will be required to make co-payments for all services, except for preventative care and family planning services, instead of monthly contributions to the POWER account.

The State proposes to include a 60-day grace period for members to make their payments. After 60 days, an individual would be disenrolled and locked-out for six months. When the individual re-enrolls, the individual is required to pay any debt that accrued due to non-payment. HIP Plus participants who make all required contributions to their POWER accounts during the year will be eligible to roll-over a portion of the unused share of the balance to the next Plan year.