

Indiana Medicaid Expansion Waiver

Overview

Indiana's Medicaid expansion began on February 1, 2015 and is authorized through January 31, 2018. Building on an existing 1115 waiver called the Healthy Indiana Plan (HIP), Indiana has created two plans for the new adult group. The HIP Plus Plan is available to waiver beneficiaries with incomes above 100 percent of the federal poverty level (FPL), who are required to contribute to a health-savings like account called a Personal Wellness and Responsibility (POWER) account, and includes additional benefits such as dental and vision coverage. HIP Plus is also available to beneficiaries with incomes at or below 100 percent FPL if they contribute to a POWER account. The HIP Basic Plan is available to beneficiaries with incomes at or below 100 percent FPL, and requires no contribution to a POWER account. Additionally, the state is hoping to encourage employment through a voluntary work search and job training program, although Medicaid eligibility will not be affected by enrollee participation in the program.

Populations Covered

All individuals age 19 through 64 with incomes up to 138 percent FPL are enrolled in the POWER accounts. This includes individuals eligible under the new adult group, as well as certain parents and caretaker relatives who had been eligible under the pre-ACA guidelines, those receiving Transitional Medical Assistance (TMA), and individuals who are medically frail.¹ However, parents, TMA recipients, and persons who are medically frail receive state plan benefits that are not contingent on account contributions, while those in the new adult group receive a different benefit plan depending upon whether they contribute to a POWER account.

Benefits

Indiana is not obligated to provide retroactive coverage during the first year of the demonstration under the waiver. However, Indiana is required to implement a transition program for a minimum of one year for certain low-income parents and caretakers that will reimburse providers for costs for services provided up to 90 days prior to the date the beneficiary becomes eligible for waiver services. The state is required to collect data to determine whether there are gaps in coverage. In addition, coverage begins on the first day of the month in which an individual makes a POWER account contribution, rather than the date of application. For enrollees with incomes at or below 100 percent FPL, coverage in HIP Basic begins after the 60-day grace period for contributions ends, effectively creating a waiting period prior to enrollment, even though these individuals are not required to make POWER account contributions. Presumptive eligibility will be expanded and the state will allow for so-called "fast-track" payments to help secure immediate coverage for individuals.

All enrollees in the new adult group, including those enrolled in both HIP Plus and HIP Basic have access to the alternative benefit plan,² and Early and Periodic Screening, and Diagnostic, and Treatment (EPSDT) services are covered for 19- and 20-year-olds under both HIP Basic and the HIP Plus plans. However, those who contribute to a POWER account (as described in more detail below) are enrolled in HIP Plus and have access to additional benefits such as dental and vision coverage. During Year One, the state does not need to provide non-emergency medical transportation to individuals in the new adult group. Early and Periodic Screening, and Diagnostic, and Treatment (EPSDT) services are covered for 19- and 20-year-olds under both HIP Basic and the HIP Plus plans.

Premiums and Cost Sharing

All waiver enrollees have a POWER account, which contains both state and enrollee contributions. The accounts are used to pay enrollee claims, not enrollee copayments.³ Contributions are not required of individuals with household incomes at or below 100 percent FPL, but if they do contribute to their POWER accounts, they may enroll in the HIP Plus program. Individuals with household incomes above 100 percent FPL are required to make monthly POWER account contributions based on income. All enrollees may reduce the amount of their monthly contributions if they receive preventive services.⁴ (See table 1 below for details.)

Table 1. POWER Account Contribution Levels and Effect of Non-Payment

Income range	Monthly contribution	Effect of non-payment
at or below 100% FPL	2% of income (those with incomes below 5% FPL pay no more than \$1)	Enrolled in the HIP Basic plan and subject to copayments.
greater than 100% FPL	2% of income	Contributions are a requirement of eligibility. If not paid within 60 days, individuals are disenrolled and ineligible to reenroll for 6 months. Enrollees who qualify as medically frail are exempt from any lock-out period.

Enrollees in HIP Basic (including medically frail beneficiaries) must pay copayments for outpatient services, inpatient services, and prescription drugs. Enrollees in HIP Plus are not subject to additional cost sharing beyond POWER account contributions. All enrollees are subject to an \$8 copayment for non-emergency use of the emergency department for the first visit and \$25 for each visit thereafter during the first two years of the demonstration.⁵ However, the copayment is waived if the enrollee contacts his or her health plan's 24-hour nurse hotline prior to going to the emergency department.

Cost sharing for all enrollees, including copays and POWER account contributions, does not exceed 5 percent of household income as consistent with federal Medicaid requirements.. Additionally, the waiver gives Indiana authority to implement healthy behavior incentives to reduce enrollee cost sharing, but incentive details are not included in the demonstration approval document.



Premium Assistance

HIP Link, an employer-sponsored insurance premium assistance component, is optional for all new adult group enrollees over the age of 21 who have access to cost-effective employer-sponsored insurance. HIP Link enrollees receive assistance with the cost of coverage through a state-established \$4,000 POWER account. The account is used to pay the employee's premium contribution above 2 percent of income and any cost sharing the enrollee incurs in seeking health services. HIP Link enrollees do not need to contribute to a POWER account.

Delivery System

All enrollees receive services through managed care plans.

For a summary of the Section 1115 waivers used to expand Medicaid to the new adult group please see [Expanding Medicaid to the New Adult Group through Section 1115 Waivers](#).

Endnotes

¹ Transitional Medical Assistance requires states to provide at least six months, and up to 12 months, of Medicaid coverage to enrollees under Section 1931 (i.e., low-income parents and their children) when the family's income has risen above a state's current eligibility levels.

² An alternative benefit plan (ABP) offers an option to states to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups or provide services through specific delivery systems, instead of following the traditional Medicaid benefit plan. All states that expand Medicaid are required to submit an ABP to denote any differences in benefit coverage between the base population and expansion population, or to note that they are offering the same benefit coverage to all enrollees in the base and expansion populations.

³ The POWER account is used to pay for the first \$2,500 in claims and anything beyond that amount is covered by Indiana. Indiana contributes the difference between the enrollee's expected contribution and \$2,500 to the POWER account, which holds this state contribution as well as enrollee contributions and those donated by employers or other entities, such as health care providers.

⁴ These reductions are based on the remaining balance in the POWER account. For HIP Plus enrollees, receipt of preventive services will double the balance to be carried over for the new enrollment period, although the amount cannot exceed enrollees' total required contribution for the year. HIP Basic enrollees are eligible for a discount of up to 50 percent on POWER account contributions for the subsequent year.

⁵ As required by federal law, a control group that is not subject to the graduated copayments will provide the state with a benchmark to evaluate the effectiveness of the program. This provision expires January 31, 2017, although the remainder of the waiver continues until January 31, 2018.

Reference

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. 2015. Healthy Indiana Plan (HIP) 2.0. January 27. Baltimore, MD: CMS. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-ca.pdf>.

