# Indiana Waiver: Healthy Indiana Plan 2.0

Indiana received federal approval from the Centers for Medicare & Medicaid Services (CMS) for its Healthy Indiana Plan (HIP) 2.0 Medicaid demonstration in January 2015, which was initially authorized through January 31, 2018 and later extended with some changes through December 31, 2020. In October 2020, CMS extended the demonstration again, authorizing some components through December 31, 2025, and most others through December 31, 2030.

Building on an existing Section 1115 waiver, also called the Healthy Indiana Plan (HIP), HIP 2.0 includes several elements intended to promote beneficiaries' engagement in their health care, such as required monthly contributions to a health savings-like account called a Personal Wellness and Responsibility (POWER accounts) and non-eligibility periods (referred to as lock-out periods) for beneficiaries who do not comply. It also includes policies related to eligibility and enrollment, including changes to the effective date of coverage, and work and community engagement requirements as a condition of eligibility, and changes to the benefit structure. In HIP 2.0's most recent extension, CMS extended authority for work and community engagement requirements and lock-out periods for five years, conditional on the U.S. Supreme Court issuing a ruling in the case *Azar v. Gresham* that legally authorizes these elements.

The information in this fact sheet is current as of November 2020. However, the Biden Administration has since withdrawn Indiana's authority for work and community engagement requirements and notified the state that other elements of the demonstration are under review (CMS 2021).[1] Because the U.S. Supreme Court has not issued a ruling allowing non-eligibility periods, Indiana's lock-out policy is also inactive.

## Demonstration Goals

Under the most recently approved waiver, the state is seeking to accomplish several goals with HIP 2.0. The demonstration goals will inform the hypotheses in the state's evaluation design plan, which include—but are not limited to—determining whether:

- changing the structure of the POWER account from being based on a percentage of income to a tiered structure will result in more efficient use of health services, be easier for beneficiaries to understand, and increase compliance in making monthly payments;
- implementing a community engagement requirement will lead to sustainable employment and improved health outcomes among current and former HIP beneficiaries; and,
- increasing financial contributions for beneficiaries who use tobacco products will discourage their use and increase the use of tobacco cessation benefits.

## Populations Included

All individuals age 19–64 with incomes up to 138 percent FPL enroll in the POWER accounts. They include individuals eligible as part of the new adult group, adults eligible as low-income parents and caretaker relatives, individuals receiving Transitional Medical Assistance (TMA), pregnant women, and individuals who are medically frail.[2,3] Parents, TMA enrollees, pregnant women, and individuals who are medically frail receive state plan benefits that are not contingent on account contributions.[4]

# Eligibility and Enrollment

HIP 2.0 includes several policies related to eligibility and enrollment, including the effective date of coverage, beneficiary reporting requirements for annual redeterminations, and a new work and community engagement requirement.

## Effective date of coverage

Under the demonstration, Indiana is no longer required to provide three months of retroactive coverage except to pregnant women. Coverage begins on the first day of the month that an individual makes a POWER account contribution, rather than the date he or she applies for Medicaid.

Upon being determined eligible for HIP 2.0, individuals have 60 days in which to make their initial contribution. Individuals with income at or below 100 percent FPL who fail to make an initial payment are enrolled in HIP Basic effective on the first day of the month in which their 60-day period expired; those with incomes above 100 percent FPL are not enrolled.

For individuals determined presumptively eligible, HIP 2.0 coverage begins the first day of the month following approval of the full Medicaid application. They subsequently have 60 days to make their initial POWER account contribution. Applicants also have the option to expedite the start of their coverage to the first day of the month in which the payment is received by making a one-time initial $10 payment, referred to as a fast-track POWER account payment.

## Plan selection period

Once beneficiaries are enrolled in HIP, they may only switch plans during the annual selection period held from November 1 through December 15. They remain with the same managed care organization (MCO) for the entire calendar year even if they lose coverage and return to the program.

## Redetermination

HIP enrollees have a calendar-year benefit period, which runs from January through December. Enrollees are required to have their eligibility reconfirmed on an annual basis through a redetermination process that begins 45 days prior to the end of the 12-month eligibility period. If the system has sufficient information, individuals will be auto-renewed; however, if additional information is requested but not provided before coverage expires, enrollees will be subject to disenrollment.[5] Individuals subject to disenrollment will have 90 days to submit their redetermination paperwork, after which they will prohibited from re-enrolling in HIP for three months (unless they meet a good cause exemption).[6] The state is required to make a number of assurances, explained further below, including that its renewal system will comply with all applicable Medicaid requirements. The state is also required to upgrade or maintain systems for completing ex parte renewals (i.e., confirming continued Medicaid eligibility through third party data sources without requesting more information from the beneficiary), and work towards a goal of completing renewals for 75 percent of beneficiaries through this process. It is also required to provide appropriate education and outreach, full appeal rights, and reasonable modifications for people with disabilities.

## Work and community engagement requirement

Indiana began implementing work and community engagement requirements as a condition of eligibility in 2019, and planned to begin enforcing the requirements (i.e., suspending eligibility for non-compliant beneficiaries) in January 2020. However, the state announced its decision to pause enforcement of the requirements until further notice. This means that no beneficiaries are at risk of eligibility suspension in January 2021.

Under the requirements as conditionally approved, during any given month beneficiaries must either meet an exemption from the requirements or participate in qualifying work and community engagement activities in order to maintain eligibility (Table 1). Beneficiaries must document their participation in a manner consistent with processes for verifying other eligibility criteria. The state is required to provide multiple means of submission

(e.g., online, via mail, or other electronic means) and follow other general requirements established for verifying eligibility.[7] However, the special terms and conditions of the waiver do not specify how exemptions for the work requirements will be verified.

Indiana planned a phased-in approach for these requirements. The hourly requirements were set to increase gradually from zero hours per week for the first six months to a maximum of 20 hours per week after 18 months. If beneficiaries complete more than the required hours in a particular week, they can apply those hours to the rest of that month, but not to other months. In October, when the state announced that it would suspend enforcement, the hourly requirement was 10 hours per week. It is not clear how the state will count months in which the requirements are suspended for the purposes of phasing in hourly requirements.

**TABLE 1.** Work and Community Engagement Requirement Exemptions and Qualifying Activities

| Exempt populations | Non exempt populations | |
|---|---|---|
| | **Qualifying activities** | **Required hours** |
| • students (full- and part-time)<br>• pregnant women<br>• primary caregivers of a dependent child below age 13 or a disabled dependent<br>• beneficiaries identified as medically frail<br>• beneficiaries with a temporary illness or incapacity documented by a third party<br>• beneficiaries in active SUD treatment<br>• beneficiaries over age 59<br>• beneficiaries who are homeless<br>• beneficiaries who were incarcerated within the last six months<br>• beneficiaries who meet the requirements of TANF employment initiatives or who are exempt from having to meet those requirements<br>• beneficiaries enrolled in the state's Medicaid employer premium assistance program<br>• persons determined eligible for a good cause exemption<br>• members of federally recognized tribes | • employment<br>• participation in MCO employment initiatives<br>• jobs skills training<br>• job search activities<br>• education related to employment<br>• general education such as high school, GED, community college, college or graduate school<br>• accredited English as a second language education<br>• vocational education and training<br>• community work experience<br>• participation in Gateway to Work<br>• community or public service<br>• caregiving services for a non-dependent relative or other person with a chronic, disabling health condition<br>• accredited homeschooling<br>• meeting the requirements of the SNAP employment initiative or being exempt from those requirements<br>• volunteer work<br>• other workforce program (e.g., tribal program) | Required hours are phased in as the requirement is implemented:<br>• 1–6 months: 0 hours per week<br>• 7–9 months: 5 hours per week<br>• 10–12 months: 10 hours per week<br>• 13–18 months: 15 hours per week<br>• 18 or more months: 20 hours per week |

**Notes:** GED is general equivalency diploma. MCO is managed care organization. SNAP is Supplemental Nutrition Assistance Program. SUD is substance use disorder. TANF is Temporary Assistance for Needy Families. Medically frail beneficiaries include those as defined under 42 CFR 440.315(f) and as defined in the state plan's alternative benefit plan. Good cause exemptions can be defined by the state but at minimum must include, if the beneficiary is a victim of domestic violence, or if the beneficiary (or his or her immediate family member living in their home) experiences a hospitalization, serious illness, or has a disability as defined by federal law and was unable to meet requirements because of that disability.
**Source:** CMS 2018.

Once the state resumes enforcing the requirements, each December, the state will evaluate whether a beneficiary complied with the requirements. Beneficiaries are required to meet the requirements for eight months out of the year, not including any months in which they are meeting an exemption or not enrolled in HIP.

**Penalties for non-compliance.** Eligibility will be suspended on the first day of the new calendar year for beneficiaries who did not meet the required hours for the required months in the prior year. It will remain suspended until the redetermination date unless the beneficiary reactivates enrollment by becoming eligible through a different pathway, by meeting an exemption, or by completing the required hours of qualifying activities for one month and submitting documentation to the state.[8] Members whose eligibility remains suspended on the date of redetermination and do not meet the requirements during that month will be disrenrolled and required to reapply for Medicaid.

**State assurances.** Indiana is required to make a number of assurances including that it will set up and maintain system capability to implement and conduct key administrative functions, such as suspending eligibility and lifting those suspensions (which includes suspending and reactivating capitation payments to managed care organizations (MCOs), allowing beneficiaries to report work or community engagement hours, and seeking data from other sources such as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

Indiana is also required to make assurances aimed at beneficiary protection, including that it will ensure timely and adequate beneficiary notices and outreach, provide appeal and due process mechanisms, make good faith efforts to connect beneficiaries to existing community supports (e.g., non-Medicaid transportation assistance, child care, or language services), assess areas within the state that have limited employment or educational opportunities to determine whether further exemptions are necessary, and provide reasonable modifications for individuals with disabilities.

## Benefits

HIP 2.0 enrollees receive different benefit packages based on their eligibility group. The new adult group receives either the HIP Basic or the HIP Plus alternative benefit plan (ABP).[9] Early and periodic screening, and diagnostic, and treatment (EPSDT) services for 19- and 20-year-olds are provided under both HIP Basic and the HIP Plus plans. However, enrollees 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. Non-emergency medical transportation benefits (NEMT) are not provided in HIP Basic or HIP Plus, though members receiving the state plan benefit package (parents, TMA enrollees, pregnant women, and individuals who are medically frail) do receive NEMT benefits.

Other HIP 2.0 members, including new adult group members who are medically frail, low-income parents and caretaker relatives, pregnant women, and members receiving TMA benefits, receive the state plan benefit package.

The extension of HIP 2.0 in February 2018 also expanded opioid use disorder (OUD) and substance use disorder (SUD) treatment benefits to all Indiana Medicaid recipients, including services provided in residential treatment facility. These features were extended in October 2020 and authorized through December 2025. Without the waiver, federal financial participation would not be available for these services.[10]

## Premiums and Cost Sharing

HIP enrollees including the new adult group, medically frail individuals, and parents and caretakers, must pay either monthly POWER account premiums, or copayments at the point of service. Cost sharing for all enrollees, including copayments and POWER account contributions, may not exceed 5 percent of household income, consistent with federal Medicaid requirements.

**POWER accounts.** All HIP enrollees have a POWER account, which contains both state and enrollee contributions. The accounts are used to pay the first $2,500 in enrollee claims, which exempts enrollees from paying cost sharing.[11] Individuals with household incomes at or below 100 percent FPL have the option to make POWER account contributions and enroll in HIP Plus, or to enroll in HIP Basic, which instead requires copayments at the point of service.[12] Individuals with household incomes above 100 percent FPL are required to make monthly POWER account contributions as a condition of eligibility (Table 2). Since the demonstration was initially approved in 2015, beneficiaries who did not make these contributions were disenrolled and locked out of coverage for six months.[13] Under the terms of the most recent extension, the state may disenroll these beneficiaries, but may not lock them out of coverage unless authorized by the U.S. Supreme Court (see above).

**TABLE 2.** POWER Account Contribution Levels for an Individual and Effect of Non-Payment, by Poverty Level

| Income range | Monthly contribution | Effect of non payment |
|---|---|---|
| ≤ 22% FPL | $1 | Enrolled in the HIP Basic plan and subject to copayments. |
| 23–50% FPL | $5 | Enrolled in the HIP Basic plan and subject to copayments. |
| 51–75% FPL | $10 | Enrolled in the HIP Basic plan and subject to copayments. |
| 76–100% FPL | $15 | Enrolled in the HIP Basic plan and subject to copayments. |
| 100–138% FPL | $20 | • In general, contributions are a requirement of eligibility. If not paid within 60 days, individuals are disenrolled and ineligible to reenroll for 6 months.<br>• Enrollees who qualify as medically frail are enrolled in HIP Basic and subject to copayments. |

**Notes:** FPL is federal poverty level. In families with two enrolled spouses, each spouse makes his or her own POWER account contribution equal to half the required amount for an individual (except for beneficiaries below 22 percent FPL, who would each have a $1 monthly contribution).
**Source**: CMS 2018

The state may review POWER account contribution tiers annually and modify them if appropriate, although the monthly contribution cannot exceed three percent of household income.

If an HIP enrollee is identified as a tobacco user by his or her MCO, the enrollee's required contribution will rise by 50 percent. This surcharge is waived in the first year of enrollment to allow the member to take advantage of HIP 2.0's tobacco cessation benefits. If a member informs the state that he or she has stopped using tobacco, the surcharge will be removed from the following year's contribution requirement.

All enrollees can reduce their required monthly contributions by using preventive services and by maintaining a positive balance in the POWER account.[14]**Copayments at the point of service.** Cost sharing under HIP 2.0 is consistent with state plan authority. Enrollees in HIP Basic (including medically frail beneficiaries) must pay copayments for outpatient services, inpatient services, and prescription drugs, but not for preventive care services. Enrollees in HIP Plus are not subject to cost sharing for most medical services. All enrollees are subject to an $8 copayment for non-emergency use of the emergency department. However, the copayment is waived for enrollees who contact their health plan's 24-hour nurse hotline prior to going to the emergency department.[15]

## Premium Assistance

In the previous iteration of HIP 2.0, Indiana offered an optional employer-sponsored insurance premium assistance component for all new adult group enrollees over the age of 21 with access to cost-effective employer-sponsored insurance. However, Indiana discontinued this program because of low participation and high administrative burden (CMS 2017c).

## Delivery System

All enrollees receive services through managed care plans.

## Reporting Requirements

Indiana must submit an implementation plan to CMS within 90 calendar days of demonstration approval. Indiana must submit a monitoring protocol within 150 calendar days of demonstration approval that describes the quantitative and quantitative elements that will be reported. The monitoring reports must include information on demonstration operations, performance metrics, budget neutrality and financial reporting requirements, and evaluation activities and interim findings. If monitoring reports indicate that demonstration features are not likely to assist in promoting the objectives of the Medicaid program, CMS can require the state to submit a corrective action plan to CMS as an interim step to withdrawing waiver authorities.

For more on the details of Section 1115 demonstration waivers used to test new approaches to coverage, please see *Testing New Program Features through Section 1115 Waivers*.

**Endnotes**

[1] Indiana initially received approval for work and community engagement requirements in 2018 and began implementation in 2019, but later decided to suspend them indefinitely, citing a pending legal challenge in the U.S. District Court for the District of Columbia (DDC) (FSSA 2019). Indiana received approval for, and implemented, lock-out periods in 2015, but has not enforced them since early 2020, due to the COVID-19 pandemic (consistent with requirements under the Families First Coronavirus Response Act (FFCRA, P.L. 116-127) to receive the increased federal medical assistance percentage during the public health emergency).

[2] TMA requires states to provide at least 6 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 rises above a state's current eligibility levels.

[3] MACPAC uses the term pregnant women as this is the term used in the statute and regulations. However, the term birthing people is being used increasingly, as it is more inclusive and recognizes that not all individuals who become pregnant and give birth identify as women.

[4] These individuals are eligible for the new substance use disorder treatment options included in the demonstration.

[5] Pregnant women or women in their 60-day postpartum period are exempt from disenrollment. Beneficiaries who are pregnant, medically frail, or parents or caretakers (eligible under Section 1931 of the Social Security Act) are exempt from the non-eligibility or lock-out period. Beneficiaries who become pregnant or medically frail during a non-eligibility period can reenroll immediately effective on the date applicable for their eligibility category.

[6] Good cause exemptions must be provided, at minimum, to beneficiaries who become pregnant, medically frail individuals, victims of domestic violence, or members who experience a qualifying event such as obtaining and subsequently losing

private insurance coverage, having a loss of income after a prior increase that disqualified them from Medicaid, moving to another state and then returning, or residing in a county subject to a disaster declaration. Individuals meeting one of these criteria can re-enroll upon completing any remaining redetermination requirements.

[7] These include regulations at 42 CFR 435.916(c) and 42 CFR 435.945, requiring states to provide multiple means of submission from applicants and follow general requirements established for verifying eligibility.

[8] Reactivation dates depend on the circumstances for reactivation. Eligibility for members who become eligible through a different pathway will be reactivated consistent with the established policy for their new group. Eligibility for members who become pregnant will be reactivated retroactive to a prior month consistent with state policy. Eligibility for members who meet an exemption will be reactivated in the concurrent month in which the state receives notice. Eligibility for members who demonstrate completion of required hours for one month will be reactivated in the month following notification to the state.

[9] An 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 indicate any differences in benefit coverage between the base population and expansion population, or that they are offering the same benefit coverage to all enrollees in the base and expansion populations.

[10] This provision will become effective upon CMS's approval of the SUD implementation protocol. The specific details of the Indiana SUD program are beyond the scope of this fact sheet.

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

[12] Individuals in HIP Basic can transition to HIP Plus by resuming POWER account contributions during the annual redetermination period.

[13] The state provides exceptions to the lockout period for medically frail individuals, victims of domestic violence, or members who experience a qualifying event such as obtaining and subsequently losing private insurance coverage, having a loss of income after a prior increase that disqualified them from Medicaid, moving to another state and then returning, or residing in a county subject to a disaster declaration. Members who meet one of these criteria can resume coverage upon resuming their POWER account contributions.

[14] These reductions are based on the remaining balance in the POWER account. For HIP Plus enrollees, receipt of preventive services doubles 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 40 percent discount on POWER account contributions for the subsequent year (FSSA 2018).

[15] Indiana previously was approved to operate a graduated copayment structure that charged members $8 for the first non-emergent visit and $25 for subsequent visits, but this provision was not extended in the February 2018 extension.

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