

FEDERAL APPROVAL OF HIP 2.0

With the approval of the HIP 2.0 waiver, Indiana will implement a proven, consumer-driven health care model to reform traditional Medicaid. The program will consist of three different plans:

- HIP Plus, which is available to all members who contribute an affordable monthly amount.
- HIP Basic, which requires co-pays from members below the poverty line who fail to make HIP Plus contributions.
- HIP Link offers premium assistance to help members pay for their qualified employer health insurance plan.

REFORM CURRENT MEDICAID PROGRAM		
HIP 2.0 PROPOSAL	APPROVED	DESCRIPTION
End traditional Medicaid for non-disabled adults		All non-disabled adults will be transitioned from Medicaid into HIP
Increase provider reimbursement in our current Medicaid program		Reimbursement rates will increase on average by approximately 25% to increase access to coverage for current beneficiaries
PRESERVE INCENTIVE & DISINCENTIVE STRUCTURE OF HIP		
HIP 2.0 PROPOSAL	APPROVED	DESCRIPTION
6-month lock-out period for non-payment		Members above the poverty line are subject to a 6-month lock-out period for non-payment
Default in HIP Basic for non-payment		Members below the poverty line who do not make contributions are enrolled in HIP Basic, which has co-payments and fewer benefits than HIP Plus
\$25 emergency room co-pay		All members are subject to an \$8 co-pay for the first inappropriate visit to the ER and a \$25 co-pay for each subsequent inappropriate visit to the ER
Incentive to complete preventive care		All members who complete required preventive care and manage the POWER account judiciously will offset future HIP Plus contributions
ADVANCE CONSUMER-DRIVEN HEALTH CARE		
HIP 2.0 PROPOSAL	APPROVED	DESCRIPTION
POWER account		Health savings-like account for all HIP participants

continued on next page >>>

FEDERAL APPROVAL OF HIP 2.0

REQUIRE PERSONAL RESPONSIBILITY		
HIP 2.0 PROPOSAL	APPROVED	DESCRIPTION
Required contributions		Waiver of cost-sharing rules to allow required contributions for all participants, at every income level, to participate in HIP Plus
Required co-payments		Applies to individuals below 100% Federal Poverty Level who do not make contributions to their POWER account
Debt repayment		Members are responsible for debt if they leave the program early and do not make all required contributions to the POWER account
Gateway to Work		All HIP participants will be automatically referred to job training and work search programs
ALIGN WITH COMMERCIAL HEALTH INSURANCE MARKET		
HIP 2.0 PROPOSAL	APPROVED	DESCRIPTION
No retroactive coverage		Waiver of requirement for the State to pay medical bills incurred before a person becomes eligible for coverage
Commercial health benefits		Benefits offered in all HIP plans will align with those offered in the commercial market
No coverage of non-emergency transportation		Waiver of requirement to cover of non-emergency transportation, which is not covered in commercial health plans
Effective date of coverage		Coverage in HIP Plus begins only after individuals make payment; Individuals below the poverty line who do not make an initial contribution must wait 60 days after applying to begin coverage in HIP Basic
Limits on plan changes		Members may change their managed care plan only up until the time they make their first contribution; Changes after that time must be reviewed on a case-by-case basis by the State