



HEALTHY INDIANA PLAN FREQUENTLY ASKED QUESTIONS (FAQs)

Eligibility

Who is eligible for The Healthy Indiana Plan?

The Healthy Indiana Plan (HIP) will provide health insurance for uninsured adult Hoosiers between 18-64 whose household income is between 22 - 200% of the federal poverty level (FPL), who are not eligible for Medicaid. Eligible participants must be uninsured for at least 6 months and cannot be eligible for employer-sponsored health insurance.

How is this plan different from a traditional entitlement program?

The number of people who can enroll in the Healthy Indiana Plan is entirely dependent upon available funding. Eligibility will be on a first-come, first-served basis.

HIP requires each participant to make a modest financial contribution, and it provides incentives for participants to stay healthy, be value and cost-conscious, and to utilize services in a cost-efficient manner. This plan covers essential health services and is similar to commercial plans. In contrast, Medicaid has unlimited benefits and services, and recipients have no incentive to be responsible for their health status, to be mindful of costs, or to utilize health care services efficiently.

What if you are income eligible but you already have insurance? Can you drop your existing healthcare coverage and join The Healthy Indiana Plan?

No. The Healthy Indiana Plan is only open to Hoosiers who have been uninsured for a minimum of six months. The six-month requirement is intended to prevent people from dropping their existing private health coverage just to join HIP.

What if your employer offers health insurance, but you have chosen not to participate?

If a person has access to employer-sponsored health insurance, he or she is not eligible for HIP.

What about COBRA or a cancer only policy is that considered health insurance?

COBRA is health insurance but if you exhausted your COBRA benefits you do not have to wait another six months to be eligible for HIP. Disease specific policies such as cancer policies are not considered health insurance. Accident policies and other policies designed to give the person income for periods of hospitalization, certain loss of limbs, or expenses incurred from accidents are also not considered health insurance.

What if you do not qualify for the plan, but are still uninsured. Are there any buy-in options?

Yes. A person earning above 200% FPL, who has been uninsured for six-months and does not have access to health insurance through their employer may purchase the plan at full cost, with no subsidy from the State. Price will vary depending on the age, gender, and health risk assessment.

Also, if for some reason the plan has reached maximum enrollment, individuals below 200% of the FPL that would normally qualify for HIP can purchase the plan at the discounted Healthy Indiana Plan rates. However, the individual will be responsible for the entire cost and the State will offer no subsidy.

Are individuals who are deemed to be “high risk” eligible for the Healthy Indiana Plan?

Yes. Part of the HIP application will include questions on an individual’s recent health status. Individuals who have high-risk conditions will be assigned to a plan that will be able to provide diagnosis-related enhanced disease management services and will allow member access to medical providers specializing in the individual’s particular healthcare conditions.

Will having a pre-existing condition or a high-risk condition affect by eligibility?

No, a pre-existing condition or high-risk condition has no bearing on your eligibility for HIP? You can still participate but you may be assigned to a plan that is best suited to serve your health care needs.

What if I am on the Medicaid Aged, Blind, and Disabled (ABD) program? Can I withdraw my eligibility and participate in Healthy Indiana Plan? What if I am eligible for Medicaid with a spend-down?

No. If you are currently eligible for Medicaid, with or without a spend-down, you are not eligible for HIP.

What happens if I become pregnant while enrolled in Healthy Indiana Plan?

Pregnant women do not qualify for HIP, as pregnancy services are covered by the Hoosier Healthwise program. If a woman becomes pregnant while on HIP, her pregnancy will not be covered by HIP. She will be eligible for HHW and can change programs by submitting proof of pregnancy and a change report form to the State. At that time she will be removed from HIP, and all of her medical services, pregnancy-related and other, will be covered under Package B of Hoosier Healthwise. The State will also pay for any services incurred for the pregnancy during the time the program switch was made. She will receive a prorated balance of her POWER Account upon leaving the program. Following her pregnancy, she may enroll back in the HIP plan. The plan she chooses will be responsible for helping her with the transitions to assure seamless coverage.

Plan Benefits

What does the HIP plan offer?

- Basic ***commercial benefits*** package once annual medical costs exceed \$1,100.
- ***A POWER Account*** valued at \$1,100 per adult to pay for initial medical costs. Contributions to the account are made by the State and each participant (based on a sliding scale). No participant will pay more than 5% of his/her gross family income into the POWER Account, although many will pay less.
- Coverage for ***preventive services*** up to \$500 a year at no cost to participants. After the \$500 is met, preventative services are covered but the POWER account must be used if necessary.
- Co-pays are required for all emergency services only. However, the co-pay will be returned if the service was deemed a true emergency by prudent layperson standard.

What services are covered?

Covered services include: physician services, prescriptions, diagnostic exams, home health services, outpatient hospital, inpatient hospital, hospice, preventive services, family planning, and case and disease management.

Are mental health services covered?

Yes. Mental health coverage is similar to coverage for physical health, and includes substance abuse treatment, inpatient, outpatient, and prescription drugs.

Are vision and/or dental covered?

No. Although vision and dental coverage was in the original Indiana Check-up legislation, the federal government did not approve this addition.

Does the Healthy Indiana Plan discourage Hoosiers from using their plan for critical health care services such as preventive care? How will Hoosiers be healthier under The Healthy Indiana Plan?

The Healthy Indiana Plan includes free preventive health services for up to \$500 a year. Services such as annual physicals, mammograms, colorectal screenings, and smoking patches will help Hoosiers avoid many costly services in the future by catching health problems earlier and encouraging them to adopt healthier lifestyles. Upon annual renewal, participants who received all of their age and gender appropriate preventive services will be rewarded by a transfer of their remaining balance in their POWER Accounts – see POWER Accounts below.

Are brand name drugs and over the counter medicines covered?

Coverage for brand name and over-the-counter medicines will vary by plan.

How long do the benefits last?

The coverage term is 12 months. After the one year term, the participant must re-certify and fill out the necessary paperwork to be authorized to continue in the plan for another 12 months.

The Healthy Indiana Plan Contribution Requirements

How much will participants contribute financially? What if you are already paying premiums for your children to participate in Hoosier Healthwise?

Participants will contribute no more than 5% of their gross family income to have the security of health insurance. The exact amount of the contribution will depend on income and family size, based on a sliding scale. The contribution will be reduced by the amount of any Hoosier Healthwise premium.

Sliding scale for individual contributions (based on % of gross family income):

- 0-100% FPL: 2%
- 101%-125% FPL: 3%
- 126%-150% FPL: 4%
- 151%- 200% FPL: 4.5% for caretaker relatives /parents living with a dependent child
- 151%-200% FPL: 5% for adults not residing with a dependent

See attached chart for more specific information on required contributions based on income and family size.

What is the policy on late payments? When does an individual get terminated from the Plan?

Individuals will be required to make a contribution every month. If an individual does not make a payment within 60 days, coverage is terminated.

When coverage is terminated for this reason, in addition to losing medical coverage, the individual cannot reapply for 12 months. If an individual chooses not to renew participation after 12 months in the plan, the individual may not reapply for the plan for at least 12 months. They will also face a 25% penalty on the remaining balance of their POWER Account and will not be able to receive the full proportional balance of their contribution.

Are the contributions made to the POWER Accounts premiums? Are the contributions tax-deductible like traditional health savings accounts (HSAs)?

No. Unlike a premium, participants can potentially recover the funds that they contribute if they manage their POWER Account wisely- see POWER Account section below. The POWER Account, while modeled in the spirit of an HSA, is not an HSA, and therefore is not tax-deductible. Most persons who qualify for this plan do not earn enough to qualify for the tax deductions that are typically associated with HSAs.

What if my income or circumstances change? Will my POWER Account contribution amount change?

Participants may request one change to their POWER Account contribution during the 12 month term of their plan if they have a “qualifying event.” Qualifying events include loss of job, and reductions in work hours. Family size changes including divorce, legal separation, birth or death can be considered at any time.

POWER Accounts

What is a Personal Wellness Responsibility (POWER) Account, and how will participants pay for the first \$1,100 in health care services?

Like HSAs, all participants will have a POWER Account established in their name, in addition to a health plan that will cover health care expenses above the POWER Account. The account will contain the monthly contributions made by participants, in addition to a State contribution, for a combined total of \$1,100. Participants can use this to pay for the first \$1,100 of their initial medical expenses.

How much does the State contribute to the account?

In addition to paying for the health care plan, the State also makes a contribution to the member POWER account. The contribution will vary according to a sliding scale based on a participant’s financial contribution to the account. The State will subsidize the account to ensure there is a total of \$1,100 in the account. For example, if a participant’s contribution is \$600 annually, the State will contribute \$500.

Does the State make its contribution on a monthly basis as well?

No. The State will make its entire contribution at the time of enrollment to ensure there is money in the account when the plan begins.

What happens if a participant incurs medical costs before the POWER Account is fully funded?

Similar to common practice today, the insurer will advance payment to the provider for the service, and then deduct the amount from the POWER Account when future contributions are made. Individuals are still responsible for these “advance payments.”

How can a plan participant access funds in their POWER Account?

The insurance carrier will administer the POWER Accounts to pay eligible medical expenses up to the account limit of \$1,100.

What happens when the POWER Account is depleted?

Once the POWER Account is used up, the insurance plan will then cover all medical expenses up to \$300,000 per year or \$1 million of lifetime expenses. No additional cost sharing will be required except for non-emergency use of the emergency department.

Are there any restrictions on how the funds can be used?

The account can only be used to pay plan providers for authorized services and will not work in other circumstances.

What happens if there is money left in the individual's POWER account at the end of the year?

If all pre-defined age and gender preventive services are completed and submitted to the insurer, then all remaining POWER Account funds (including State and individual) will rollover to offset the following year's contribution.

If preventive services are not completed, only the individual's pro-rated contribution to the account (not the State's portion) rolls over.

What if the person is no longer eligible for the program?

The individual will receive a pro-rated amount of their contribution. They will not receive any of the State's contribution. For example, if the individual contributed 50% of the account, or \$550, they will receive half of whatever is left in the account. So, if there were \$500 left, they would receive \$250

What if the person is no longer eligible, due to non-payment?

They will receive only 75% of their prorated contribution. So in the above example, they would only get 75% of \$250, or \$188.00. In addition, the individual cannot return to the program for 12 months.

What if the insurer has paid a provider in advance and the participant leaves the program early without paying all their monthly contributions?

The insurer will try to collect this from the participant. If the participant does not pay, they will register the debt with the State. The individual must clear the debt before they can receive services in the HIP program in the future.

Administration

Who will administer The Healthy Indiana Plan? Will this be another Family and Social Services Administration (FSSA) program?

The State has contracted with Anthem and /MDWise with Americhoice, which are commercial insurance carriers, to provide coverage for HIP.

Will participants be able to choose what plan they participate in?

Yes. Individuals will be able to indicate their plan preference when they sign up directly on their application or through an enrollment broker. If a choice is not made, the individual will be assigned to a plan. Families or two individuals in the same household may choose different plans but will be responsible for submitting separate POWER account contributions to the different plans. High-risk individuals will be assigned to the Enhanced Services Plan (ESP) that will provide enhanced disease management services as well as provide access to a special network of providers.

Can participants change plans?

Individuals can change plans only before their first POWER Account contribution has been made. After that, they will have to stay with their plan for the duration of their 12-month term. They can only change plans for poor quality of care provided by the plans. Poor quality of care is defined as:

- Action, or lack of action, by the Insurer which puts the life of health of the member at risk or jeopardizes the member's ability to reach and maintain maximum function;
- Unreasonable delay by the Insurer in granting a prior authorization request;
- Failure of the Insurer to provide services
- Corrective Action levied against the Insurer by OMPP; or
- Other circumstances determined by FSSA to constitute poor quality of care.

Will there be any variation between the plans?

Yes. The State will identify parameters for the plans. Benefits will be standard, but will allow carriers to provide enhanced services to participants and compete for participants. This free market competition is intended to help assure the high quality of plan services.

What is the role of the federal government in the Healthy Indiana Plan?

The plan financing requires a significant contribution from the federal government, and therefore, requires federal approval.

Will providers be paid at traditional Medicaid rates?

No. Providers will be paid at Medicare rates, which are approximately 30%-40% above Medicaid rates, but are still below commercial provider reimbursement rates. The Healthy Indiana Plan wants to assure there is an adequate delivery system to serve the newly insured, as well as an environment that promotes quality through competition among providers.

Employers

Can employers make a contribution to their employee's POWER Account?

Yes. Employers may elect to make contributions to the POWER Account to offset their employee's required contributions. The employer may contribute up to 50% of the individual's required contribution to the POWER Account.

What if I have more than one employer, can all of them contribute?

Plans can only collect contributions from one employer.

What keeps employers from dropping current coverage so that their employees can join the Healthy Indiana Plan?

Employers would have to drop their coverage for six months for their employees to become eligible for HIP. Because of the income criteria, not all employees may qualify, leaving those at higher incomes without coverage. Thus, employers should not be any more tempted to drop employee health care coverage than they are currently.

How will The Healthy Indiana Plan help lower the rate of health insurance premium growth for Hoosier businesses?

The Healthy Indiana Plan will significantly reduce the number of uninsured Hoosiers. With more insured Hoosiers, there is less cost-shifting to insured populations, potentially lowering the rates of premium growth.

How will the plan encourage price transparency for all Hoosiers?

Since participants will have an incentive to obtain the best possible pricing, they will seek information regarding the cost of the services they receive. Providers will be encouraged to make their pricing and quality information more accessible to all Hoosiers so consumers can make informed decisions about the services they purchase. As cost shifting is reduced, providers (and insurance carriers) will not have to inflate their costs, and the information they provide will be more accurate.

Enrollment

When does the program begin?

HIP applications will be available in November 2007, the State will begin accepting completed applications in mid December. Plan coverage will begin January 2008.

Where will individuals be able to sign up?

Applicants can download and print applications from the internet at www.hip.in.gov. Applications may also be picked up at various community organizations participating in the V-CAN network, Hoosier Healthwise Enrollment Centers, and the local Division of Family Resources (DFR) office. To find locations near you, call us toll-free at 877-GET-HIP-9. Completed applications can be submitted to the DFR county office or mailed directly to the Grant County service center at 100 N. Pennsylvania Avenue, Marion, Indiana, 46952.

How do individuals sign up? Is the process different than signing up children for Hoosier Healthwise?

The HIP application process will be similar to Hoosier Healthwise (HHW), but will utilize a different application. If a parent and child are signing up for health insurance coverage at the same time, a HIP application must be filled out for the parent, and a separate Hoosier Healthwise application must be filled out for the child. However, beginning in July 2008, we anticipate that applicants will be able to apply for health insurance as a family on one application for both HIP and Hoosier Healthwise.

Additional Information

Where do I go if I need more information?

The website for the HIP program is www.HIP.IN.gov and will contain general information as well as updates on the program as it is being developed. You may also email specific questions to hipinfo@fssa.in.gov.

For general questions, application assistance, plan choice assistance, or to contact the insurance carriers, call us toll free at (877) GET-HIP-9.

Power Account Contribution Charts

The charts below provide an estimate of various power account contributions based on family make-up and annual income. The annual contributions are calculated based on the specified percentage of income. The monthly contributions, however, can be reduced by other medical payments made within a household, including CHIP premiums made to the Hoosier Healthwise program for children. The charts below are calculated based on the following CHIP premium payments:

CHIP Monthly Premiums	One Child	Two or More Children
150%- 175% of FPL	\$22	\$33
175%- 200% of FPL	\$33	\$50

Single Adult, No Children

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
0-100%	\$0-\$10,210	2%	\$0	\$204	N/A	\$0	\$17
100-125%	\$10,211- \$12,763	3%	\$306	\$383		\$26	\$32
125-150%	\$12,764- \$15,315	4%	\$511	\$613		\$43	\$51
150-175%	\$15,316- \$17,868	5%	\$766	\$893		\$64	\$74
175-200%	\$17,869- \$20,420	5%	\$893	\$1,021		\$74	\$85

Family of 2: 1 Adult, 1 Child

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
0-100%	\$0-\$13,690	2%	\$0	\$274	\$0	\$0	\$23
100-125%	\$13,691- \$17,113	3%	\$411	\$513	\$0	\$34	\$43
125-150%	\$17,114- \$20,535	4%	\$685	\$821	\$0	\$57	\$68
150-175%	\$20,536- \$23,958	4.5%	\$924	\$1,078	\$264	\$55	\$68
175-200%	\$23,959- \$27,380	4.5%	\$1,078	\$1,232	\$396	\$57	\$70

Family of 2: 2 Adults

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
0-100%	\$0-\$13,690	2%	\$0	\$274	\$0	\$0	\$23
100-125%	\$13,691- \$17,113	3%	\$411	\$513	\$0	\$34	\$43
125-150%	\$17,114- \$20,535	4%	\$685	\$821	\$0	\$57	\$68
150-175%	\$20,536- \$23,958	5%	\$1,027	\$1,198	\$0	\$86	\$100
175-200%	\$23,959- \$27,380	5%	\$1,198	\$1,369	\$0	\$100	\$114

Family of 3: 1 Adult, 2 Children

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
0-100%	\$0-\$17,170	2%	\$0	\$343	\$0	\$0	\$29
100-125%	\$17,171- \$21,463	3%	\$515	\$644	\$0	\$43	\$54
125-150%	\$21,464- \$25,755	4%	\$859	\$1,030	\$0	\$72	\$86
150-175%	\$25,756- \$30,048	4.5%	\$1,159	\$1,352	\$396	\$64	\$80
175-200%	\$30,049- \$34,340	4.5%	\$1,352	\$1,545	\$600	\$63	\$79

Family of 3: 2 Adults, 1 Child

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
0-100%	\$0-\$17,170	2%	\$0	\$343	\$0	\$0	\$29
100-125%	\$17,171- \$21,463	3%	\$515	\$644	\$0	\$43	\$54
125-150%	\$21,464- \$25,755	4%	\$859	\$1,030	\$0	\$72	\$86
150-175%	\$25,756- \$30,048	4.5%	\$1,159	\$1,352	\$264	\$75	\$91
175-200%	\$30,049- \$34,340	4.5%	\$1,352	\$1,545	\$396	\$80	\$96

Family of 4: 2 Adults, 2 Children

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
0-100%	\$0-\$20,650	2%	\$0	\$413	\$0	\$0	\$34
100-125%	\$20,651- \$25,813	3%	\$620	\$774	\$0	\$52	\$65
125-150%	\$25,814- \$30,975	4%	\$1,033	\$1,239	\$0	\$86	\$103
150-175%	\$30,976- \$36,138	4.5%	\$1,394	\$1,626	\$396	\$83	\$103
175-200%	\$36,139- \$41,300	4.5%	\$1,626	\$1,859	\$600	\$86	\$105