Agenda

• Introduction
• Healthy Indiana Plan (HIP) Expansion
• Compare HIP 1.0 and HIP 2.0
• Benefit Plans
• Reimbursement and Copayments
• Other Information
• Questions
Introduction
Introduction
The history and successes of HIP

• HIP – Passed by the Indiana General Assembly in 2007
• Built upon the State’s long and successful history with consumer-driven health plans
• Provides an alternative to Traditional Medicaid
• Promotes consumerism by requiring members to make a financial investment in their healthcare with contributions to a Personal Wellness and Responsibility (POWER) Account
Introduction
The history and successes of HIP

• HIP members:
  – Greater success in obtaining primary and preventive care than Traditional Medicaid members
  – Utilization of hospital emergency departments for nonurgent care was lower than that of Medicaid enrollees

• Member satisfaction surveys consistently report:
  – Most members are satisfied with the program
  – Most also indicated they would reenroll if they left the program but became eligible again
**Introduction**

**HIP 2.0 Core objectives**

- Promote healthier Hoosiers
- Provide new coverage pathways for uninsured Hoosiers
- Promote employer-sponsored health insurance
- Promote personal responsibility and engage participants in making healthcare decisions based on cost and quality
HIP Expansion
HIP Expansion

• Targets an estimated 559,000 uninsured, nondisabled adults, ages 19-64 with incomes below 138% federal poverty level (FPL)
• Eliminates Traditional Medicaid for nondisabled adults ages 19-64
  – These individuals will be moved to HIP 2.0
• Current HIP members will transition to HIP 2.0
• The Family and Social Services Administration (FSSA) will continue to partner with the current managed care entities (MCEs) to administer HIP member benefits:
  – Anthem
  – MDwise
  – MHS
Compare HIP 1.0 and HIP 2.0
### Compare HIP 1.0 and HIP 2.0

#### Healthy Indiana Plan
- Membership limited
- Single benefit plan
- Annual or lifetime claim caps
- No pregnancy benefits – Covered services only during the discovery period
- **POWER Account:** $1,100 and consists of both member and State contributions
  - POWER Account funds are used to cover the first $1,100 in claims, excluding preventive services
- No dental or vision services offered

#### Healthy Indiana Plan 2.0
- No membership caps
- Four benefit plans
- No annual or lifetime claim caps
- Pregnancy benefits – All pregnancy services are covered
- **POWER Account:** $2,500 the first $2,200 is the State’s contribution
  - The member's contribution is up to a maximum of $300, but most will be much less (income based)
  - Account funds are used to cover the first $2,500 in claims, excluding preventive and pregnancy services
  - Members making POWER Account contributions will be enrolled in a HIP Plus plan, which provides a richer benefit plan. Members who do not make POWER Account contributions will default to a HIP Basic plan which assesses copayments.
- Dental and vision benefits available in some plans
## Benefit Plans

<table>
<thead>
<tr>
<th>HIP Plus</th>
<th>HIP Basic</th>
<th>HIP State Plus</th>
<th>HIP State Basic</th>
</tr>
</thead>
</table>
| • Mirrors the current HIP covered services  
• Physician services  
• Inpatient and outpatient services  
• Prescription drugs  
• Routine dental and vision service  
• Pregnancy-related services  
• Copays apply to nonemergent ER visits only  
• POWER Account contributions | • Mirrors the current HIP covered services  
• Physician services  
• Inpatient and outpatient services  
• Prescription drugs  
• No routine dental or vision  
• Pregnancy-related services  
• Copays apply to outpatient, inpatient, preferred drugs, nonpreferred drugs and nonemergent emergency room (ER) visits | • Mirrors the current Indiana Medicaid covered services including:  
• Chiropractic  
• Nonemergent transportation  
• Routine dental and vision  
• Long-term care  
• Copays apply to nonemergent ER visits  
• POWER Account contributions | • Mirrors the current Indiana Medicaid covered services including:  
• Chiropractic  
• Nonemergent transportation  
• Routine dental and vision  
• Long-term care  
• Copays apply to outpatient, inpatient, preferred drugs, nonpreferred drugs and nonemergent emergency room (ER) visits |

The Automated Voice Response (AVR) system and Web InterChange will be available for providers to verify HIP 2.0 member eligibility and benefit plan.
## Benefit Plans

<table>
<thead>
<tr>
<th>HIP Benefit Code</th>
<th>HIP Package Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RBC</td>
<td>HIP Basic with copay (no dental/vision)</td>
</tr>
<tr>
<td>RBN</td>
<td>HIP Basic no copay (no dental/vision)</td>
</tr>
<tr>
<td>RPC</td>
<td>HIP Plus with POWER contribution (dental/vision)</td>
</tr>
<tr>
<td>RPN</td>
<td>HIP Plus with no Power contribution (dental/vision)</td>
</tr>
<tr>
<td>SBC</td>
<td>HIP State Plan BASIC copay</td>
</tr>
<tr>
<td>SBN</td>
<td>HIP State Plan BASIC no copay</td>
</tr>
<tr>
<td>SPC</td>
<td>HIP State Plan PLUS with POWER contribution (dental/vision)</td>
</tr>
<tr>
<td>SPN</td>
<td>HIP State Plan PLUS no POWER (dental/vision)</td>
</tr>
</tbody>
</table>
Reimbursement and Copayments
Reimbursement

HIP Plan reimbursement rates:

• HIP rates will not be less than the federal Medicare reimbursement rate for the service provided; or
• At a rate of 130% of the Medicaid reimbursement rate

*Facility services provided to Low-Income Parent/Caretaker aid category members will be reimbursed based on the Medicaid Fee Schedule
## Copayments

### HIP Basic and State Basic Plan copays

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP Basic and State Basic Copay Amounts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Services</td>
<td>$4</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$75</td>
</tr>
<tr>
<td>*Preferred Drugs</td>
<td>$4</td>
</tr>
<tr>
<td>*Nonpreferred Drugs</td>
<td>$8</td>
</tr>
<tr>
<td>Nonemergency ED visit</td>
<td>Up to $25</td>
</tr>
</tbody>
</table>

*Preferred and nonpreferred drug list are determined by the member MCE*
Other Information

- The Centers for Medicare & Medicaid Services (CMS) is currently reviewing the HIP 2.0 application; it has not yet been approved.

- Information contained within this presentation is subject to change based on the terms of CMS’ approval.

- Additional information will be published in future IHCP Banner Pages and IHCP Bulletins.

- Providers that wish to participate in HIP 2.0 must be enrolled with the Indiana Health Coverage Programs (IHCP) and one or more of the MCEs.
  - Start the enrollment process now to prevent contracting delays.
  - Contact HP Provider Relations for help with your IHCP enrollment.
Other Information

• Contact the MCEs for credentialing and enrollment information and assistance

• Contact the MCEs for additional information about HIP 2.0 claims submission, processing, and prior authorization procedures

• **Anticipated go-live date – January 1, 2015!**