DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-12
Baltimore, Maryland 21244-1850

State Demonstrations Group

October 22, 2015

Joseph Moser
Medicaid Director
Indiana Family and Social Services Administration
402 W. Washington Street, Room W461
Indianapolis, IN 46204

Dear Mr. Moser:

The State of Indiana submitted its HIP Link Protocol on May 26, 2015 as required by Special Term and Condition (STC) VI.3, under its section 1115 demonstration, Healthy Indiana Plan 2.0 (HIP 2.0) (Project No. 11-W-00296/5). During the time subsequent to approval, the Centers for Medicare & Medicaid Services (CMS) and the state collaborated to reach approval of the protocol.

At this time, we have no further questions about the HIP Link protocol. With this letter, CMS approves the state to move forward with implementation of the final version of the protocol, which is attached to this letter and incorporates comments CMS provided on the state's original submission. As required by the HIP 2.0 STCs, the attached HIP Link Protocol will replace the preliminary HIP Link protocol in Attachment A of the STCs.

We look forward to continuing to work with you and your staff on the HIP 2.0 demonstration. If you have any questions, please contact your project officer, Ms. Shanna Janu, at either 410-786-1370 or by email at Shanna.Janu@cms.hhs.gov.

We appreciate your cooperation throughout the review process.

Sincerely,

/s/

Andrea J. Casart
Acting Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Ruth Hughes, Associate Regional Administrator, Region V
Tannisse Joyce, CMS Chicago Regional Office

HEALTHY INDIANA PLAN

HIP Link Protocol

10/22/2015

HIP Link is new program offered by the State of Indiana to help low income Hoosiers pay for their employer-sponsored health insurance. This optional program is designed to offer assistance to cover a portion of the employee's premium cost and out of pocket costs associated with employer group health insurance.

Contents

HIP Link Description

a. A description of the HIP Link program.

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals who have access to HIP Link qualifying employer sponsored insurance (ESI). HIP Link allows HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP. This option increases choice for beneficiaries and reduces crowd out of private health insurance.

HIP Link maintains HIP's consumer directed framework by providing enrolled individuals with a HIP Link Personal Wellness and Responsibility (POWER) account valued at $4,000 for the initial coverage year. The attached Milliman document discusses how the state determined the amount of the POWER account. The state will begin HIP Link using the $4,000 amount, however based on the program's experience, the state may adjust this amount in the future or may adjust on a case-by-case basis. This Health Savings like account holds the state's defined contribution for ESI coverage of $4,000 and will cover the premiums and out of pocket costs associated with enrollment in ESI. The POWER account will be established and managed by the state. Additionally, the account serves as supplemental coverage for medical expenses incurred during the employer's annual coverage period. Like HIP Plus, individuals enrolled in HIP Link will be required to contribute 2 percent of their income towards the cost of their employer sponsored insurance. Premiums will be deducted from the employee's paycheck as usual, and the state will send the employee pre-payment for the difference between the premium amount and their 2 percent POWER account contribution.

The individual who elects to enroll into HIP Link will receive the benefits offered by the HIP Link qualified employer health insurance instead of the HIP Plus, HIP Basic, or HIP State Plan benefits as applicable. HIP Link beneficiaries will access benefits provided through their employer sponsored insurance.

The state will provide HIP participants with support as they contemplate enrolling in HIP or HIP Link. The state's enrollment broker will provide counseling to assist them with their decision. The enrollment broker will have access to information detailing the benefits in each employer sponsored plan and will be able to explain the differences between HIP and HIP Link, as well as answering questions about HIP Link.

HIP Link Cost Sharing

b. Cost sharing requirements for HIP Link participants including examples of the interplay between the employer premium contribution, employee premium contribution, and state premium contributions, and the POWER account.

HIP Link participants will be responsible for paying 2 percent of their income, but not less than one dollar per month, towards the cost of their employer sponsored insurance. The employer will deduct the full cost of the employee premium from the individual's paycheck. Once a month, the HIP Link enrolled ESI policy holder will receive a check prospectively from the state

for the difference between their 2 percent required contributions and their required premium payments for the next month.

Once an applicant is found eligible for HIP Link, the HIP Link coverage will begin the first day of month in which they also are enrolled in HIP Link eligible ESI coverage on the first day of the month. The first check received by a new Link enrollee will compensate the enrollee for any premiums already paid for the current month of enrollment in the ESI. For example, if the applicant is found eligible in June and ESI coverage begins June 15, HIP Link coverage will start July 1. However, since the member must enroll in ESI to receive HIP Link and ESI coverage rarely starts on the first of the month, the member's initial payment will account for the prospective monthly cost of enrollment, from July 1 to July 31, as well as the cost for the June 15 to July 1 timeframe.

To ensure that the pre-payment to the individual is accurate, on a monthly basis all HIP Link eligible employers will confirm the HIP Link member's continued eligibility for ESI and the premium amounts that will be deducted for the next month's coverage. A schedule showing pre-payment and verification timelines is included as Enclosure 1.

The 2 percent contribution for enrolled eligible spouses is based on household income and shared between spouses and dependents that reside in the household, regardless of whether they are enrolled via HIP Link. Dependents added to ESI that do not reside in the household per the modified adjusted gross income rules will have a separate 2 percent of income contribution and will provided a $4,000 POWER account. In the commercial market dependents may stay on their parents ESI policy until age 26.

The premium deduction and pre-payment process does not change for enrolled spouses or dependents. If a Link eligible dependent is enrolled in ESI with their Link eligible parents, the Link eligible employee will still be paying the entire premium for the family, so the enrolled employee will receive the pre-payment for the individual plus spouse or family premium amount.

The $4,000 HIP Link POWER account is allocated between required premiums for the enrollment year and the cost sharing the individual may owe on the employer plan. The allocation of the HIP Link POWER account is dependent on the employer plan. For example, a plan with no cost sharing may have $4,000 allocated to premiums, whereas and a plan with no employee premium may have $4,000 allocated to cost sharing. The HIP Link enrollee's 2 percent of income premium contribution is in addition to this amount, so a Link enrollee, regardless of the amount of their 2 percent contribution will always have a $4,000 defined contribution from the state to cover the costs of premiums and out-of-pocket costs on the employer plan. When two or more individuals in a family are enrolled together, the HIP Link accounts are combined. For example, enrolled spouses will have a combined $8,000 HIP Link account. Like an account for a single enrolled employee, a portion of the combined account is allocated to the ESI premiums, and the remainder of the account covers the out-of-pocket costs for ESI on a first in-first out basis, regardless of which enrolled Link individual the claim applied to. The following are examples of the Link account allocation for an individual only and with an enrolled spouse.

HIP Link POWER Account Allocation Examples			
	HIP Link Enrolled Employee	**HIP Link Enrolled Employee & Spouse**	**HIP Link Employee and non-residing Dependent**
Annual Income	$16,000	$22,000	Employee: $16,000 Non-Residing Dependent: $8,000 Total: $22,000
2 percent Annual Contribution	$320	$440	Employee: $320 Non-Residing Dependent: $120 Total:$440
State Contribution to HIP Link Account	$4,000	$8,000	Employee=$4,000 Non-residing Dependent=$4,000 Total: $8,000
Total Available Funds for Premium and Cost Sharing	$4,000+ $320 = **$4,320**	$8,000+$440 = **$8,440**	$8,000+$440 = **$8,440**
Annual Employee Portion of Premium	$470	$1,500	$1,500
Account funds allocated for premium pre-payment	$470-$320 = **$150**	$1,500-$440=$**1,060**	$1,500-$440=$**1,060**
Monthly Premium Pre-payment	$150/12= **$12.50**	$1,060/12= **$88.33**	$1,060/12= **$88.33**
POWER Account funds available for cost sharing	$4,000-$150= **$3,850**	$8,000-$1,060= **$6,940**	$8,000-$1,060= **$6,940**

HIP Link enrollees receive a HIP Link card, in addition to the insurance card supplied by the ESI health plan, which serves as proof of their supplemental coverage. At the time of service, enrollees will present both the ESI primary and HIP Link supplemental coverage cards. Providers will bill the ESI as primary insurance coverage. The portion of cost that is defined as individual responsibility in the form of a deductible, copay, or coinsurance is then submitted to HIP Link by the provider. HIP Link will pay the member's portion of the service, using the primary insurance contracted rate. Provided the individual has HIP Link funds and uses a provider that is both in-network with Medicaid and with their primary insurance, they will not be responsible for any cost sharing for services covered by their primary insurance. If the individual does not have sufficient HIP Link funds or uses a provider that is not in network for Medicaid but is in-network for their primary insurance, they will responsible for the maximum allowable Medicaid cost sharing amounts. Cost sharing will not be applied to pregnant members, Native American Members, or members that have met their 5 percent of quarterly income cost sharing limit.

	Maximum allowable cost sharing	
Services	**Individuals with family income ≤100% of the FPL**	**Individuals with family income > 100% FPL**
Outpatient Services (*physician visit, physical therapy, etc.*)	$4	The greater of $4 or 10% of cost the agency pays
Inpatient Stay	$75	The greater of $75 or 10% of total cost the agency pays for the entire stay

Preferred Drugs	$4
Non-Preferred Drugs	$8
Non-emergency Use of the Emergency Department	$8

Individuals that visit non-Medicaid providers that are in-network with the employer plan will have to submit proof of payment and proof such as an explanation of benefits that the service was covered by the primary insurance and then will be reimbursed and have the Medicaid allowable cost sharing applied deducted from their reimbursement. HIP Link will not cover balance billing by providers that are not in network with Medicaid or the primary insurance coverage.

HIP Link will also cover services, required by the alternative benefit plan that may not be covered by the primary insurer including family planning at non-network providers, 72-hour emergency supply of pharmaceuticals, FQHC and RHC services, and non-emergency transportation for low-income parents and caretakers. Payments for these services will come from the HIP Link POWER account. The services that allow cost sharing may have copayments attached when the member POWER account is depleted. Low-income parents and caretakers, transitional medical assistance, or women that become pregnant and elect to stay in HIP Link at their redetermination period, will have access to non-emergency transportation benefits. These services will be reimbursed at state plan Medicaid reimbursement rates. Provider entities required to be reimbursed on the prospective payment system (PPS) will always be paid at the prospective payment system (PPS) rates, unless the service is covered by the individuals ESI and the ESI payment rate for the service is higher than the PPS rate. Payments will come from the HIP Link account, and the rate paid will be either the primary insurance patient responsibility portion of the contracted rate if it is higher than the PPS rate or the PPS rate. The state's fiscal agent manages the POWER account and will determine the appropriate rate to pay for these services based on the claim received and the PPS rate for the service.

Other than the 2 percent contribution to the employee premium, HIP Link eligible individuals have no cost sharing unless their HIP Link account is exhausted or they use a non-network provider. All cost sharing is subject to a 5 percent quarterly limit. The 2 percent monthly premium contribution counts towards this amount, and any medical expenses for which the individual provides proof of payment and receives reimbursement with a copayment applied will be accrued towards the 5 percent cost sharing limit. The state will track electronically enrollee costs toward the 5 percent cap for claims submitted via HIP Link. Individuals may submit receipts for this service and have these payments count towards their 5 percent of income cost sharing limits. Individuals must be seen by a Medicaid enrolled provider in order for HIP Link to be able to pay the medical claim through the standard claims process. If individual does not go to a Medicaid enrolled provider then they may submit receipt to the state for reimbursement. Reimbursement will be provided less the applicable copayment as discussed above.

If the HIP Link account is projected to become exhausted during the remaining enrollment period, the State will do a cost-effectiveness analysis on an individual basis to determine if it is more cost-effective from the perspective of the state to allow the individual to remain enrolled in HIP Link or for them to move back to HIP.

Cost-effectiveness analysis will be triggered by 70 percent of the funds allocated for cost-sharing being exhausted. One claim (for a catastrophic event) could exhaust all cost-sharing funds, so in some cases, cost-effective analysis may not start until the amount allocated for cost-sharing is depleted.

Cost-effectiveness will be determined on the expected cost to enroll the individual in HIP compared to the cost of remaining enrolled in HIP Link. The individual's care utilization and remaining amount before hitting the ESI out-of-pocket maximum will be considered in determining if remaining in HIP Link is more cost-effective. If it is more cost-effective to allow individuals to remain enrolled in HIP Link then the state will continue to pay the individual's out-of-pocket costs and premiums for the ESI coverage. If it is less cost-effective to remain in Link, the state will enroll the individual into HIP Plus for the remainder of their benefit year and the individual will be disenrolled from HIP Link. Individuals may only reenroll in ESI and receive HIP Link at ESI open enrollment or once every two years with a special enrollment. The State would prefer to give individuals the option to remain in HIP Link, however, per the requirements of the HIP 2.0 Special Terms and Conditions, if it is not cost effective for them to remain in HIP Link and retain the cost sharing protections required by law, then the individual will be given notice of the transfer from HIP Link to HIP and will not be allowed the choice to remain in HIP Link (so as not to violate the cost sharing protections required by law).

HIP Link members that complete a year of coverage in HIP Link will be eligible for rollover. The HIP rollover is detailed at Section 7 #11 in the HIP STCs. HIP Link rollover is similar to HIP Basic Rollover in the initial coverage year and will be based on the amount remaining in the HIP Link POWER account. HIP Link enrollees may reduce their future year's HIP Link contribution amount by up to 50 percent based on the percentage of HIP Link funds remaining in their HIP Link account. In future years of HIP Link enrollment, HIP Link enrollees may be eligible to increase this rollover to 100 percent if they participate in an employee wellness program or complete recommended preventive services.

The POWER account(s) for spouse and/or dependent(s) are not available to HIP Link members if spouse and/or dependent(s) is/are no longer covered by the employer plan during the benefit period. HIP Link enrollees will be subject to cost-effective analysis if spouse and/or dependent(s) are removed from the employer plan and this puts them at risk of exhausting the remaining account. HIP Link POWER accounts exist to pay claims not yet received due to claims lag and will be reconciled after claims runout has completed. HIP Link POWER accounts do not hold member money, so there is no forfeiture of payments made on the behalf of members when the POWER accounts are closed.

HIP Link Health Plan Requirements

c. The benefits and cost sharing requirements for employer sponsored plans in the program.

To be eligible as an ESI plan in which a HIP Link eligible individual can enroll, the plan must meet both benefit and affordability requirements.

Benefit Requirements

HIP Link benefits are indexed to the HIP Link alternative benefit plan which is based on the State of Indiana's commercial essential health benefit benchmark. These benefits in the state's ABP serve as the benefit floor for EHB that must be offered by health plans eligible for employer sponsored insurance. Provided that each essential health benefit category is present and the plan meets the benefit actuarial value requirements, employer sponsored insurance may have varying benefits. Complete detail of the HIP Link benefits is provided in the HIP Link Alternative Benefit Plan State Plan Amendment.

In addition to meeting the state's essential health benefit requirements, health plans also cannot offer elective abortion for which federal funding is prohibited and must meet mental health parity requirements.

Depending on the type of health plan applying for coverage, the Indiana Department of Insurance (IDOI) may already have completed an in depth review of all of these requirements as noted on the chart below.

	Small Group Health Plan that meets the 2014 ACA requirements	Large Group Plan updated to meet the 2014 ACA requirements	Small Group Health Plan NOT updated for 2014 ACA requirements	Large Group Plan NOT updated for 2014 ACA requirements	Self-Funded	Non-Indiana Plan
EHB / MV	Compliant	Verify Compliant	Verify Compliant	Verify Compliant	Verify Compliant	Verify Compliant
Abortion[1]	Compliant	Compliant	Verify Not Offered	Verify Not Offered	Verify Not Offered	Verify Not Offered
MHPAEA [2]	Compliant	Verify	Verify	Verify	Verify	Verify

DESCRIPTION OF TERMS

Compliant: Health plan meets the requirement because the department of insurance has reviewed the plan.
Verify Compliant: HIP Link team need to verify compliance with this requirement .
Verify Not Offered: HIP Link team needs to verify that the coverage does not exceed allowable coverage.

For example, if the plan applying for Link eligibility is a state licensed small group QHP plan then the state is assured that this plan already meets all of the benefit requirements and no further benefit review will be necessary. For large group plans that are reviewed by the IDOI, these plans may have been filed in tandem with a small group plan and be guaranteed to meet all applicable benefit requirements or they may have benefits that vary slightly from the state EHB and require further review.

[1] §27-8-13.4-2

[2] Mental Health Parity and Equity Addiction Act (MHPAEA) - The parity protections ensure that limits applied to mental health and substance use disorder services are not more restrictive than limits applied to medical and surgical services.

To assist the state with review when applying, plans must attest to either offering the state EHB *or* meeting the minimum value requirements required by federal law and offering benefits in all applicable essential health benefit categories.[3] Plans that do not meet one of these requirements will not be eligible to proceed with the HIP Link application process. All plans that apply will be required to provide documentation of the benefits offered along with their application including a summary of benefits and coverage and more detailed schedule of benefits. These documents will be used in the health plan review process as detailed in the following section.

Affordability Requirements

In addition to meeting benefit requirements, an employer plan must meet the HIP Link affordability test. Plan affordability is a function of the premiums the employer applies to employees and eligible dependents enrolled in their plan, the plan deductibles, coinsurance, out-of-pocket maximums and any funds in the form of Health Reimbursement Accounts (HRA) that are provided by the employer to cover the costs of coverage. Since some of these requirements vary by employer, it is possible that a small group plan that is Link eligible with one employer is not Link eligible with another employer due to a higher premium amount or not offering an HRA.

The state's actuary, Milliman Inc., has developed an affordability tool that takes inputs of employee premium contribution amounts, plan deductibles, out of pocket maximums, average coinsurance, and employer HRA contributions. These inputs are compared to the funding available in the HIP Link POWER account ($4,000 for an individual and $8,000 for a couple, etc.), the projected costs of coverage on HIP Link with the applicable cost sharing limits, and the costs of coverage in HIP. Those that exhaust their account may have the opportunity to move back to HIP if it is cost effective for the state. Otherwise, the individual will remain in HIP Link after exhausting their account and the individual will have continued assurance that cost sharing will not exceed the Medicaid allowable limits.

If the affordability tool analysis determines that the employer plan is less costly than standard HIP, then the plan will be considered affordable and eligible for HIP Link. An analysis of the funding for the HIP Link POWER account and the HIP Link affordability tool is attached with the submission.

The HIP Link affordability calculations are subject to change based on actual program experience after implementation. Any changes will be described in subsequent updates to this protocol, and subject to CMS approval.

HIP Link Health Plan Review Process

d. The criteria and process by which the state shall review and certify employer plans for the HIP Link program.

[3] The state will not make ESI plans ineligible for Link if they do not offer pediatric dental and vision, since HIP Link will wrap EPSDT.

Health plans may be received either through employer application or through insurer submission.

Employer Application Process

The state has developed an online HIP Link Portal through which employers may submit their health plans for consideration of HIP Link eligibility. During the application process, employers will be asked to confirm:

- That they have at least one employee that is a resident of Indiana
- That they have a valid FEIN
- That they contribute at least 50 percent of the cost of the premium to the plans

Employers that do not meet these basic requirements will not be eligible to be HIP Link employers. Once they complete the registration process and verify they meet these basic HIP Link employer eligibility criteria, the employer will be asked to submit details of their employer sponsored health insurance. These details will include if they offer a self-funded or fully insured plan. The Employer Counseling Team (ECT) will confirm with the employer and the Indiana Department of Insurance if the employer plan has already been through review to confirm it meets Indiana's Essential Health Benefits requirements.

After indicating plan type, all employers will be asked to verify if their plan covers abortions for which federal funding is prohibited, if their health plan meets the mental health parity requirements and if the health plan meets the benefit requirements.

<table>
<tr><td>1</td><td>Indiana Essential Health Benefits
Indiana's Essential Health Benefits available at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/indiana-ehb-benchmark-plan.pdf.</td><td><u>OR</u></td><td>Minimum Value plus coverage of specified benefit categories
Minimum value calculator available at http://www.cms.gov/site-search/search-results.html?q=minimum%20value%20calculator.
Benefit coverage for 9 benefit categories: 1) Ambulatory patient services, 2) Emergency services, 3) Hospitalization, 4) Maternity and newborn care, 5) Mental health and substance use disorder services, 6) Prescription drugs, 7) Rehabilitative and habilitative services and devices, 8) Laboratory services and 9) Preventive and wellness services.</td></tr>
<tr><td>2</td><td colspan="3">Mental Health Parity and Addiction Equity Act (MHPAEA)
Provides mental health and substance use disorder benefits at parity with medical benefits available at http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.</td></tr>
<tr><td>3</td><td colspan="3">Abortion
Does not cover abortion for which federal funding is prohibited reference at http://www.cms.gov/site-search/search-results.html?q=abortion%20for%20which%20federal%20funding%20is%20prohibited.
Does not cover elective abortions reference at https://iga.in.gov/legislative/laws/2014/ic/titles/027/articles/008/chapters/13.4/.</td></tr>
</table>

In addition to these confirmations, employers will upload the summary of benefits and coverage document, their premium rates, a benefit schedule for each plan offered and provide detail on if they also offer vision or dental insurance. Employers will also enter in details of any HRA contributions available to employees including the amount of these contributions. Due to IRS

restrictions, contributions to Health Savings Accounts must be suspended if the employee enrolls in HIP Link.

Employer Plan Review Process
The state HIP Link Employer Counseling Team (ECT) will receive the data entered by the employer on the portal, including the employer's benefit verifications, HRA amounts and uploads of premium rates, summary of benefits and coverage documents and schedule of benefits documents. Utilizing this data, the ECT will review the submitted health plans to determine if they are HIP Link eligible plans. Samples of the types of documents that the state expects to be uploaded by the employer are attached with the submission.

Affordability Review
The ECT will confirm that the employer indicated that they cover at least 50 percent of the premium for the ESI and verify this attestation with the upload of the ESI premium rates. Any employer that does not cover at least 50 percent of the premium will not be eligible for Link.

The ECT will review the premium rate document and the summary of benefit and coverage document and identify the below amounts:

- Monthly premium rate for an enrolled employee, monthly premium rate for an employee plus spouse, and monthly premium rate for an employee plus dependents.
- Single employee and family deductible.
- Single employee and family out-of-pocket maximum.
- Plan average coinsurance.

Once these amounts are identified, the ECT will input the amounts into the plan affordability tool along with any HRA contribution the employer provides. When the tool is populated with these inputs, it will return a result that indicates if the plan is affordable or not.

The tool will calculate all enrollment possibilities with the above inputs and will also be able to be run separately for a single enrollee, and an enrollee plus spouse or enrollee plus dependents. Since premium rates, deductibles, and out of pocket maximum amounts are different for the employee only and the employee plus spouse and dependents, some health plans may meet the affordability standard for HIP Link when only a single individual is enrolled, but not meet it if a spouse is also enrolled, even when accounting for the availability of a $4,000 POWER account for each Link enrolled individual. Information on which plans are affordable for individuals, spouses and families is provided to the enrollment broker for use in options counseling.

If the tool yields that the plan is affordable, the ECT will note which type of enrollments the plan is affordable for (e.g. employee only, employee plus spouse, employee plus dependents), and proceed to the benefit review phase. If the tool does not find the plan affordable, then the ECT will communicate this to the employer. Members employed by this employer will not be able to enroll in HIP Link, and will be enrolled in HIP.

Benefit Review

The level of benefit review conducted by the ECT depends on type of plan that is being reviewed. The ECT will confirm with the employer and the Indiana Department of Insurance if the submitted plan has already been reviewed for meeting the state's Essential Health Benefit (EHB) requirements. Only employers that have indicated they meet the basic requirements for employers and that their plans meet the benefit requirements will be able to submit plan documentation.

If the plan has already been reviewed for compliance with the state's EHB with the IDOI, then the ECT will not complete additional review and will consider the health plan to meet the HIP Link benefit requirements. This will be the case for all Small Group Plans that comply with the 2014 Affordable Care Act requirements.

When reviewing large group health plans, the ECT will contact the IDOI to verify if the plan submitted by the employer was submitted in concert with a small group plan. In cases where the Large Group and Small Group plan were submitted together, the Large Group plan will have the same benefits as the small group plan, and will be guaranteed to meet the state's EHB requirements.

For large group plans that are submitted separately from small group plans, and for self-insured plans that are not reviewed by the IDOI, the ECT will leverage the plan documentation submitted by the employer. The ECT will specifically review the summary of benefits and coverage for items listed as excluded to ensure no Essential Health Benefits categories are excluded from the plan and will also verify there are no dollar amount limits on any essential health benefits categories. Benefits present in the plan will be reviewed for alignment with the Indiana Essential Health Benefits including a review of benefit visit limits. In the case of identified variation/s in benefits between the HIP Link ABP and the ESI plan, the plan will be reviewed to ensure that it either meets an actuarial equivalency on an aggregate basis using the process described in 42 CFR 441.335 and 441.340 OR is actuarially equivalent on a benefit to benefit basis comparison within the same EHB category. Plans that offer all the benefits present in the EHB but have lower visit limits will be eligible for HIP Link, and the HIP Link POWER account will assure coverage for visits up to the EHB limit. During the benefit review all EHBs will be addressed; however, specific attention will be paid to coverage of (1) preventive services to ensure that all ACA required preventive services are covered by the plan,(2) maternity services, (3) rehabilitative and habilitative services, (4) review of mental health and substance use disorder treatments to assure that that the plan meets the mental health parity requirements and (5) coverage of prescription drugs. The Indiana EHB that will be used as reference for HIP Link plan review is submitted with this protocol.

The ECT may contact the employer, the health insurer or third party administrator if they have questions about the plan benefits. If the plan does not offer benefits that meet the Indiana Essential Health Benefit requirements or are substantially equal or actuarial equivalent in the aggregate or on a benefit by benefit basis within the same EHB category to the benefits described in the HIP Link ABP then the health plan cannot be a HIP Link eligible plan.

Insurer Application Process
Insurers that sell group products in the Indiana market will be able to submit plans to the ECT to have them determined HIP Link eligible on the basis of benefits offered. Since premiums and HRA contributions vary by employer, insurer submitted plans cannot be confirmed to be HIP Link eligible, however, if an employer is applying with a plan that has already been determined to offer benefits that meet the HIP Link standards, then the benefit review process described above in the employer section is not needed. However, the affordability analysis will still be completed on an employer by employer basis.

Initially, health insurers offering group health policies or third party administration services will be able to submit detail on their health plans to the ECT. The ECT will conduct outreach to these health plans, provide detail on the benefit requirements of HIP Link, and ask these health insurers to submit the summary of benefits and coverage, schedule of benefits, and proof of meeting the state EHB standards as noted above in HIP Link Health Plan Benefit Requirements on pgs. 6-7. The ECT will review the submitted documentation, verify that the plan has submitted sufficient proof of meeting the benefit requirements, and for plans that qualify the state will issue the plan a HIP Link plan ID. Employers may use this plan ID when applying for HIP Link, and employers that use the HIP Link plan ID are not required to upload benefit documentation as part of their application.

HIP Link Premium Pre-payment Process

e. The process by which the state shall pre-pay employees for the state premium contribution and administer the POWER accounts for HIP Link beneficiaries.

As detailed in the cost sharing section, HIP Link participants will be responsible for paying 2 percent of their income towards the cost of their employer sponsored insurance. The employer will deduct the full cost of the premium from the individual's paycheck. Once a month, the individual will receive a check prospectively from the state for the difference between their 2 percent required contributions and their required premium payments for the next month. The first check received by a new Link enrollee will compensate the enrollee for any premiums already paid for coverage during their Link enrollment and will pre-pay the enrollee for the next month's enrollment. To ensure that the pre-payment to the individual is accurate, on a monthly basis all HIP Link eligible employers will confirm the HIP Link member's continued eligibility for ESI and the premium amounts that will be deducted for the next month's coverage. HIP Link employers will complete this confirmation through the Employer Portal. A schedule showing pre-payment and verification timelines is included as Enclosure 1. HIP Link enrollees that receive payments for months in which they were not enrolled in ESI will be subject to benefit recovery. Employees subject to benefit recovery will be billed by the state for months where premiums were paid, but the individual was not enrolled in the employer-sponsored insurance. Recoupment of premiums paid in error may also be deducted from individual state tax returns.

HIP Link Eligibility and Transition Process

f. A protocol that ensures that those who lose access to ESI or whose plan is no longer Link eligible will be enrolled promptly into HIP Plus without a gap in coverage.(or if they have incomes below the poverty line and do not elect to make POWER account contributions will move to HIP Plus without a gap in coverage), and that sets forth any adjustment to the individual's POWER account (affecting only the unspent value of the POWER account).

Individuals not currently enrolled in HIP may enroll in HIP Link if they select HIP Link on their Indiana Health Coverage Application. Applicants may provide their employer's HIP Link ID. If the applicant does not provide the employer's HIP Link ID, the ECT will research the employers HIP Link ID through the HIP Link Employer portal, and the applicant will also be sent a request to verify the employers HIP Link ID. The requests sent to applicants will be part of the standard eligibility verification process and will ask the applicant for their employer's HIP Link ID. Asking the applicant to provide the employer's HIP Link ID gives the applicant the maximum possible chance to enroll in HIP Link as requested, since the state cannot guarantee that they will be able to match the individual with the HIP Link employer if the information is not provided on the application. If the applicant can be matched to HIP Link eligible employer and is verified as eligible for HIP, then the employer will be asked to verify that the individual is employed and enrolled in HIP Link eligible ESI. If enrolled in ESI, then the applicant will be enrolled in HIP or HIP Link per the below schedule:

a. If the applicant is currently enrolled in HIP Link eligible ESI at the time of verification and was eligible for and enrolled in ESI at the beginning of the month, then the applicant will be enrolled in HIP Link effective the 1st of the month of the application date.
b. If the applicant is not currently enrolled in HIP Link eligible ESI or was not enrolled in HIP Link eligible ESI effective on the first of the current month, but is enrolled in ESI effective the first of the following month, then the applicant will be enrolled in HIP Link effective the 1st of the month following eligibility verification.
c. If the applicant is eligible for enrollment in HIP Link at a future date, for example the applicant must wait 60 days for ESI eligibility due to an employer waiting period, they will be enrolled into HIP as a conditionally eligible HIP Plus member. The member will be enrolled into HIP Link on the first day of the month in which they are eligible for a full month of ESI coverage.

If the applicant's employer is not yet confirmed to be eligible for HIP Link (e.g., the state is reviewing the affordability of the employer health plan), then the applicant will be enrolled as a HIP Plus conditional member. The applicant may choose to change to HIP Link at any time if the employer's HIP Link eligibility is confirmed, and the employer is enrolled in HIP Link. Current HIP members who want to enroll in HIP Link, do not have to file an application to enroll. They may use the standard change reporting process to request HIP Link enrollment. The member will need to provide the HIP Link ID of their employer, or the ECT will research the HIP Link ID. If the current HIP member can be matched with a HIP Link employer, the HIP Link employer will be sent a verification request through the employer portal to confirm that the HIP member is enrolled in or eligible for enrollment in ESI. If the member is eligible for or enrolled in the HIP Link qualified ESI, they will be enrolled in HIP Link effective the first of the

month in which the employer can confirm concurrent HIP Link enrollment. There will be no break in coverage as they transition from HIP to HIP Link.

In HIP Link, eligible individuals' 12-month redetermination periods will be aligned with the employer benefit period, as appropriate. For example, if the individual enrolls in HIP Link in July and the employer plan year ends on December 31, the individual's first Medicaid redetermination will occur so that their new HIP Link benefit period begins January 1 in concert with the employers new plan year. This allows the individual's $4,000 POWER account contribution to align with the employers benefit year.

If enrolled in HIP, then the applicant will be enrolled in HIP Link per the below schedule:

a. HIP members that are currently enrolled in ESI will be transferred to HIP Link effective the 1st of the month after the enrollment in HIP Link eligible ESI is confirmed by the employer.
b. HIP members that are eligible for immediate enrollment in ESI will be transferred to HIP Link effective the 1st of the month which the employer confirms they have ESI enrollment for the entire month.
c. HIP members that are eligible for future enrollment in ESI will be transferred to ESI effective the 1st of the month where the employer confirms active enrollment in HIP Link eligible ESI for the entire month.

For applicants or enrollees who have ESI eligibility beginning in the month prior to their HIP Link enrollment, compensation for their premium payments will consider the entire benefit period of their ESI enrollment. For example, if the individual is eligible for HIP Link eligible ESI effective July 17th and the employer's benefit plan year is through December 31st, then the premium compensation for the individual will be calculated on the premium due from July 17th to December 31st. The individual will be eligible for HIP Link effective August 1, but will receive premium compensation for their entire enrollment period in ESI (July 17-December 31st).

Employers of individuals that have requested HIP Link enrollment, but who are not HIP Link eligible employers will be targeted for outreach by the HIP Link ECT to promote employer enrollment in HIP Link.

Applicants and HIP enrollees are only eligible for one HIP Link special enrollment per continuous Medicaid or HIP eligibility period. Special enrollment is an event as specified by the federal Department of Labor that allows an individual to enroll in Employer sponsored insurance outside of an open enrollment (see http://www.dol.gov/elaws/ebsa/health/4.asp#Special_Enrollment). HIP Link will allow people to access this special enrollment only once over a 2-year period in order to prevent multiple HIP Link POWER accounts in the same 12-month period. Eligible members may always enroll in HIP Link during their employer's open enrollment period. Applicants and enrollees may always elect to enroll in HIP Link during their employer's open enrollment period.

American Indiana/Alaska Natives (AI/AN) would have to opt into HIP Link. They would not be subject to cost sharing.

HIP Link Counseling Process

g. The counseling process and related materials used to counsel prospective beneficiaries.

All individuals that select HIP Link will be informed that HIP Link is coverage that provides a defined contribution to help pay for the costs of employer sponsored insurance including premiums, deductibles, copayments and coinsurance. Individuals will also be informed that HIP Link will replace their current HIP coverage and that they may contact the enrollment broker with specific questions about the benefit differences between their ESI coverage option and HIP coverage. Counseling also includes information for beneficiaries about the time frames and circumstances under which a person may disenroll from HIP Link.

Enrollment counseling for HIP Link is performed by the state's enrollment broker that currently assists HIP eligible individuals with MCE plan selection and with understanding the differences between HIP Plus, HIP Basic and HIP State Plan benefits. HIP Link eligible individuals may seek counseling:

a. Before applying for HIP Link or requesting a transfer from HIP to HIP Link
    - In this counseling the individual could find out if their employer was a HIP Link qualified employer, what types of benefits were on the employer plan, and how this compares to the HIP coverage options.
b. After applying for HIP Link, but prior to the ESI coverage start date
c. When exiting HIP Link

The enrollment broker currently educates HIP members and prospective members on the benefits in HIP Basic, HIP Plus and HIP State Plan. HIP Link will be added to this current education strategy. When an employer applies for HIP Link, they upload their plan documentation including their summary of benefits and coverage and their benefit schedule. The enrollment broker will use their existing knowledge about the HIP benefits combined with the uploaded documents to counsel the beneficiary on the differences between the HIP and HIP Link benefits. Counseling will be tailored to every individual, based on questions and concerns raised by the individual about the benefits that are most important to them. For example, if an individual applying to Link is currently receiving physical therapy on a weekly basis, the enrollment broker will be able to tell the individual how the specific physical therapy benefits will vary between HIP and HIP Link by reviewing the employer documentation. The enrollment broker will provide all individuals requesting counseling with a broad overview of the differences between HIP and HIP Link benefits and be equipped to answer specific questions about the benefits which the specific caller is most interested. The enrollment broker may also utilize the affordability tool or affordability summary documents to provide customized information on the plan cost sharing for the enrolling individual.

In addition to the uploaded employer documents on the benefits provided, the enrollment broker will have access to detailed analysis on the difference between HIP benefits and the state's EHB

benefits, which will be the benefit review standard for HIP Link eligible plans, and notes from the ECT reviewers which will indicate unique features of the plan benefits and any variation from the state's EHB. With these resources, the enrollment broker will be equipped to offer all HIP Link eligible members individualized counseling on the differences between HIP and HIP Link benefits.

HIP Link Disenrollment Process

h. Any circumstances that would allow an individual to disenroll from HIP Link and enroll into HIP Plus, including the ongoing process to self-identify as being medically frail and move out of HIP Link and into the ABP that is the state plan benefit package.

Individuals may disenroll from HIP Link if:

a. The HIP Link enrollee becomes medically frail
    - HIP Link will accept individual attestation of medically frail. If an individual becomes medically frail, they will report a change to the Division of Family Resources through the standard change reporting process. The individual will be asked to complete the medically frail questionnaire where they attest to their medically frail health status. Completion of the questionnaire is required to be considered frail for a HIP Link to HIP transfer, but verification of the condition noted on the questionnaire will take place after the transfer. The individual who requests the transfer and completes the questionnaire will have their coverage changed from HIP Link to HIP State Plan Plus. The individual's Managed Care Entity will be responsible for verifying the frail status as is the case for all other medically frail enrollees in HIP. If the frail status is verified, the individual will remain enrolled in HIP State Plan Plus, if not the individual will transfer to HIP Plus per the standard HIP medically frail process.
b. The HIP Link enrollee becomes pregnant, or at any point during the pregnancy
    - Pregnant women may elect to stay in HIP Link or transfer to HIP or Medicaid for Pregnant Women (HIP Maternity) at any time. Regardless of where they receive benefits once they report their pregnancy, they will be exempt from cost sharing. In HIP Link enrolled pregnant women will receive full compensation for their premium payment to the employer. Pregnant women may elect to remain in HIP Link at redetermination.
c. Low-income parents and caretakers and transitional medical assistance
    - These individuals may elect to transfer from HIP Link to HIP at any time.
d. They exhaust their HIP Link POWER account funding for out-of-pocket expenses and HIP Link is determined to no longer be cost effective for the HIP Link enrollee.
e. The employer no longer is HIP Link eligible, or the ESI coverage option is no longer HIP Link qualified.
f. The individual loses access to the employer ESI.
g. The spouse or dependent is no longer eligible for HIP Link.
    - In this case the spouse or dependent may disenroll from HIP Link.

HIP Link Appeals Process

i. The appeals procedure for HIP Link.

HIP and HIP Link member eligibility decisions are appealable to the State through the Medicaid fair hearing process, in accordance with at 42 CFR § 431.201 et seq. The process to appeal is detailed on all eligibility notices. These appeals would include, but not be limited to an individual's eligibility for HIP Link, an individual's 2 percent of income contribution amount, and HIP Link coverage start dates.

Appeals relating to benefits covered on the employer-sponsored plan must be addressed first to the employer's health insurance carrier. HIP Link members must first complete the internal appeal process with the employer's health plan. After completing this process, HIP Link members can appeal a delay or action related to benefits covered on the employer's health insurance to the state Medicaid agency. This opportunity for a Medicaid fair hearing will be provided in accordance with Medicaid fair hearing requirements at 431.201 et seq, including time frames in 42 CFR § 431.244. Benefits that are determined medically necessary or otherwise covered under Medicaid (i.e. under amount duration and scope) based on the state Medicaid fair hearing decision will be covered for the member.

Provider appeals on payment will be addressed through the standard Medicaid fair hearing appeals process.

HIP Link Education

j. The state's strategy for educating beneficiaries and employers on the HIP Link program.

The state will conduct targeted outreach to health insurers and employers about HIP Link. This outreach will include specific information about the HIP Link program including one page program overviews, FAQs, Step-by-Step Application Guides, and program manuals including a specific manual for employers and enrolled HIP Link members. HIP Link member manuals include program specifics including details on premium pre-payments, how to transition in and out of HIP Link, and how to access their HIP Link and wrapped benefits.

Insurers can identify plans that may be HIP Link eligible and submit them to the ECT. Employers may log onto the HIP Link Employer Portal and apply to become a HIP Link employer. Once approved as a HIP Link employer per the process discussed above, employers may market their HIP Link eligibility to their employees.

Current and potential beneficiaries will be informed about HIP Link through the states HIP marketing and outreach campaign.

Enclosure 1: HIP Link Employee Pre-payment Schedule

HIP LINK EMPLOYEE PREMIUM PRIMARY PAYMENT SCHEDULE
2015

May-15						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Sep-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

09/29 payment is for the month of Octobe

Jun-15						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

06/30 payment is for the month of July

Oct-15						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

Jul-15						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

Nov-15						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
7	9	10	11	12	13	14
14	16	17	18	19	20	21
21	23	24	25	26	27	28
28	30					

Aug-15						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Dec-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

12/29 payment is for the month of Januar

Validation Due Primary

Primary Refund Date

HIP LINK OFF-CYCLE EMPLOYEE PREMIUM PRIMARY PAYMENT SCHEDULE

FOR NEWLY ENROLLED MEMBERS

2015

May-15						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Sep-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

New enrollments after 08/18/15

09/29 payment is for the month of October

Jun-15						
S	M	T	W	TH	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

New enrollments after 05/19/15

06/30 payment is for the month of July

Oct-15						
S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

New enrollments after 09/15/15

Jul-15						
S	M	T	W	TH	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

New enrollments after 06/16/15

Nov-15						
S	M	T	W	TH	F	S
1	2	3	4	5	6	7
7	9	10	11	12	13	14
14	16	17	18	19	20	21
21	23	24	25	26	27	28
28	30					

New enrollments after 10/20/15

Aug-15						
S	M	T	W	TH	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

New enrollments after 07/21/15

Dec-15						
S	M	T	W	TH	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

New enrollments after 11/17/15

12/29 payment is for the month of January

Validation Due Primary Payment Cycle

Primary Refund Date

*Off-Cycle Pro-rated Refund Date **

Jan-16						
S	M	T	W	TH	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

New enrollments after 12/15/15

**** Refund will be prorated based on number of days remaining in month.***
Subsequent payments will be paid on Primary Refund Date