Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L- [ ]

OMB Expiration date: 10/31/2014

Employer Sponsored Insurance and Payment of Premiums — ABP9

The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	Yes

Provide a description including the population covered, the amount of premium assistance by population, required contributions, cost-effectiveness test requirements, and benefits information.

HIP Link is an optional defined contribution insurance program for all HIP eligible individuals including individuals eligible in the adult group, as low income parent and caretakers or 19 and 20 year olds, or TMA eligibles who have access to HIP Link qualifying employer sponsored insurance (ESI). As detailed in ABP 1, HIP Link also offers the opportunity for continued coverage under employer sponsored insurance for women who are pregnant at their redetermination. HIP Link allows these HIP eligible individuals to choose to enroll into their qualifying ESI instead of into HIP or Medicaid as applicable.

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. 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.

HIP Link provides enrolled individuals with a $4,000 HIP Link Personal Wellness and Responsibility (POWER) account. 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.

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.

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 mail the employee pre-payment checks for the difference between the premium amount and their 2 percent POWER account contribution. Individuals 2 percent contributions are in addition to the $4,000 provided by the state to cover premiums and out of pocket costs. 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. 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.

To be eligible for HIP Link, 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 may vary by employer, it is possible that a small group plan that is HIP Link eligible with one employer is not HIP Link eligible with another employer due to a higher premium amount or not offering an HRA.

The state's actuary, Milliman Inc., has developed a plan 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.), average HIP Link enrollee 2% contribution limits, the projected costs of coverage on HIP Link with the applicable cost sharing limits, and the costs of coverage in HIP. 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.

Individuals enrolled in 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. Benefits offered on the employer plan are reviewed for alignment with the ABP which are based on the state essential health benefits and that coverage in all EHB categories, with the exception of pediatric dental and vision is required.

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 and be accessed by providers submitting claims to HIP Link utilizing the information on the member's HIP Link card. 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.

HIP Link members that complete a year of coverage in HIP Link will be eligible for rollover. 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.

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

The beneficiary will receive a benefit package that includes a wrap of the following: FQHC and RHC services, family planning services, EPSDT for individuals under 21 and, for applicable populations as specified in this ABP SPA, non-emergency transportation. Further information related to ABP9 is contained in Indiana's HIP 2.0 1115 Demonstration and associated HIP Link protocol.

PRA Disclosure Statement

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