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OVERVIEW OF THE HEALTHY INDIANA PLAN (HIP)

The Healthy Indiana Plan (HIP) is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective January 1, 2008, and it was authorized to continue through January 31, 2014.

HIP 2.0 is a demonstration waiver approved under Section 1115(a) of the Social Security Act effective February 1, 2015, and is authorized to run for 3 years and is subject to renewal. The authority for this program is derived from the Special Terms and Conditions approved by the Centers for Medicare and Medicaid Services (CMS), along with regulations at 405 Indiana Administrative Code Article 9.

HIP provides a comprehensive benefit plan for eligible uninsured adults. It is a high-deductible health plan that utilizes an account similar to a health savings account called the POWER account – Personal Wellness and Responsibility Account – which provides incentives for members to obtain recommended preventive care.

The following sections of this chapter explain the eligibility requirements and methodologies used by the Division of Family Resources to determine HIP 2.0
eligibility and the policies regarding POWER account contributions. Additional information about HIP 2.0 and how to apply can be found on the website www.in.gov/fssa/HIP/.

3515.00.00 GENERAL ELIGIBILITY REQUIREMENTS: AGE AND HEALTH INSURANCE

To qualify for HIP, an individual must:

1) Be at least age 19 but not yet age 65
2) Not be enrolled in or eligible for enrollment in the federal Medicare program.
3) Not be eligible and not enrolled in another Medicaid assistance category, except for HIP members who become pregnant.
4) Have countable household income equal to or less than 133% of the federal poverty level (FPL).

An applicant who may be eligible both for HIP and another Medicaid category will first have his/her eligibility assessed for the other category of Medicaid. An individual may be enrolled in HIP only if she is ineligible for the other aid category. However, a person claiming to be disabled may be approved for HIP pending a determination for Medicaid disability. If later found eligible for another Medicaid category, HIP must be discontinued to allow for the person’s eligibility to be transferred to the other category the following month.

3515.05.00 Medically Frail

Medically frail means an individual who is determined to have any one of the following:

1) A disabling mental disorder
2) A chronic substance abuse disorder
3) A serious and complex medical condition
4) A physical, intellectual, or developmental disability that significantly impairs the individual’s ability to perform one or more activities of daily living.
5) A disability determination from SSA but is not eligible for MA A, MA B or MA D due to income or resources

HIP health plans will confirm the member’s frailty within 60 days of the member’s authorization to receive HIP benefits. Effective January 1, 2016, HIP health plans will confirm the member’s frailty within 30 days of the member’s

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1 405 IAC 10-4-1.
2 405 IAC 10-2-1
authorization to receive HIP benefits.

3515.10.00 Other Medicaid and Medicare Coverage

An eligible Medicaid recipient enrolled in another category cannot choose to voluntarily withdraw from another Medicaid category for the purpose of enrolling in HIP. However, a HIP recipient that becomes eligible for another Medicaid category (excluding pregnancy, refer to 3515.05.10) must have HIP discontinued so that the recipient is eligible in the other Medicaid category. Additionally, DFR must evaluate whether the person is entitled to any retroactive coverage under the other Medicaid category, since HIP benefit begin dates are determined upon financial contribution to a POWER account.

In situations of dual processing, it is important to inform the applicant/AR that HIP coverage will not be removed retroactively. For applicants that are in a nursing facility or are in the process of being approved for a waiver, it is best practice to pursue the MA D process as opposed to process for HIP coverage.

Medicare beneficiaries are categorically ineligible for HIP. If a HIP member becomes eligible for Medicare, including eligibility for retroactive Medicare benefits that overlap HIP eligibility, HIP eligibility shall cease to allow for advanced notice of adverse action (see section IHCPPM 2232.00.00). However, the health plan is prevented from recovering any payment for services, where there was overlapping Medicare and HIP coverage, when the member’s overlapping Medicare coverage is limited to Part A only.

3515.15.00 Minimum Essential Coverage of Dependents

This section is not applicable to low-income parent/caretakers, TMA, and low-income 19/20 year-olds.

HIP applicants/recipients, who are either a parent or other caretaker relative of a dependent under 19 are required to have their dependents covered under Medicaid, CHIP, or other minimum essential coverage. This is considered verified through attestation by the applicant/recipient parent/caretaker. Such dependents that have applied for or are receiving Medicaid or CHIP meet this requirement.

3515.20.00 OTHER GENERAL HIP ELIGIBILITY REQUIREMENTS

The Medicaid requirements outlined in Chapter 2400 regarding the following are applicable to the HIP program:
Requirement to provide a Social Security Number;

State residency;

Assignment of medical rights and medical support cooperation (does not apply to pregnant women and HIP TMA eligible recipients);

Citizenship status, including the documentation requirements;

Emergency-services-only health coverage is available for eligible immigrants who categorically qualify for HIP. Refer to section 3515.00.00. Immigrants who categorically qualify for HIP with limited emergency-services-only will be placed under the MARB category, and the effective date of coverage will be the month benefits are authorized by DFR. Immigrants eligible under MARB with limited emergency-only coverage will not be placed into managed care with a HIP health plan. Immigrants who categorically qualify for HIP with limited emergency-services-only are not required to make any financial contribution to a POWER account. The month of authorization is viewed as the month the payment would have been made had the person been subject to POWER account contributions. DFR must not delay authorization of benefits when an immigrant has met and verified all financial and non-financial requirements to be determined eligible for MARB with limited emergency-services-only. There is no retroactive coverage for any individual receiving emergency services under HIP.

3520.00.00 CATEGORICAL ELIGIBILITY FOR HIP

The following subsections explain the categorical requirements for each HIP category.

3520.05.00 American Indian/Alaska Native

This category is identified in ICES as MANA.

An American Indian or Alaska Native eligible for MARP or MASP will also have the option to Opt-out to MANA. Coverage under MARP or MASP is a managed-care health plan, but MANA provides fee-for-service coverage that is equivalent to Package A, but specific to the HIP program. Once an eligible American Indian/Alaskan Native is authorized under HIP Plus or HIP State Plan Plus they will have the option to Opt-out into MANA. An American Indian/Alaskan Native who meets the eligibility requirements for HIP eligibility shall not be subject to any cost-sharing requirements under any HIP category.[2] In order to be eligible for no cost-sharing the individual must be a “verified” American Indian/Alaska

[2] 405 IAC 10-4-7
Native. Please refer to section 2403.00.10 for a list of acceptable documents.

**3520.10.00 HIP Plus-State Plan (MED 3)**

This category is identified in ICES as MASP.

To be eligible for MASP an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age and have income less than 133% of the FPL, unless the person qualifies for TMA. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. Participants included are:

1. Low-income parents and caretaker relatives
2. TMA eligible individuals
3. Low-income 19/20 year olds
4. Individuals who qualify as medically frail

HIP Plus State Plan requires the member to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MASP members who become pregnant or are American Indian/Alaska Natives are not required to make financial contribution to a POWER Account. The HIP PLUS State Plan has no provision for retroactive coverage. The effective date of HIP PLUS State Plan coverage begins the first day of the month in which the individual makes an initial POWER account contribution.

**3520.15.00 HIP Basic-State Plan (MED 3)**

This category is identified in ICES as MASB.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age with income at or below 100% FPL, unless the person qualifies for TMA. The individual will be enrolled in HIP Basic State Plan if they fail to make financial contributions towards a POWER account and meet one of the following groups:

1. Low-income parents and caretaker relatives
2. TMA eligible individuals
3. Low income 19/20 year olds
4. individuals that qualify as medically frail

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3 405 IAC 10-3-2
An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. The HIP Basic State Plan has no provision for retroactive coverage. The effective date of HIP Basic State Plan coverage begins in the month in which the 60 days to make a power account contribution has expired.\(^4\) MASB members who become pregnant will no longer be required to make co-pays for services throughout their pregnancy as well as the 60-day post-partum period.

3520.20.00 HIP PLUS-State Plan with Co-pays (MED 3)

This category is identified in ICES as MAPC.

To be eligible in this category an adult must have been eligible under MASP, while being determined medically frail, having income between 100% FPL and 133% FPL, and fail to make ongoing financial contributions to a POWER account. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program. There will be no lockout periods for MAPC AGs. The effective date of MAPC coverage begins in the month in which the 60 days to make a power account contribution has expired. MAPC members who become pregnant will no longer be required to make co-pays or contributions for services throughout their pregnancy as well as the 60-day post-partum period.

3520.25.00 HIP Regular Plus (MED 3)

This category is identified in ICES as MARP.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible for any other Medicaid category.\(^5\) The income standard is 133% FPL. HIP Regular Plus requires the participant to pay a monthly POWER Account contribution (PAC) and only has co-payments on non-emergency use of the hospital emergency department. MARP members who become pregnant are not required to make a financial contribution to a POWER Account throughout their pregnancy as well as the 60-day post-partum period. The HIP PLUS State Plan has no provision for retroactive coverage. The effective date of

\(^4\) 405 IAC 10-3-2
\(^5\) 405 IAC 10-4-1
HIP PLUS coverage begins the first day of the month in which the individual makes an initial POWER account contribution.  

3520.30.00    HIP Regular Basic    (MED 3)

This category is identified in ICES as MARB.

To be eligible in this category an adult must be an Indiana resident who is at least 19 years of age and less than 65 years of age with incomes at or below 100% FPL will be enrolled in HIP Basic after failing to make financial contributions to a POWER account within 60 days of authorization. An individual may not be enrolled in or eligible for enrollment in the federal Medicare program or be eligible under any other Medicaid category. The HIP Basic benefit package applies co-payments to services. The “HIP Basic” plan maintains essential benefits, but incorporates reduced benefit coverage and a more limited pharmacy benefit. The HIP Basic plan has no provision for retroactive coverage. The effective date of HIP Basic coverage begins when the client does not make a POWER account contribution within the sixty (60) day payment period. MARB members who become pregnant are no longer required to make co-payments for services throughout the rest of their pregnancy as well as during the 60-day post-partum period.

3525.00.00    HIP EFFECTIVE DATE FOR ELIGIBILITY

For individuals meeting all financial and non-financial requirements to be considered HIP eligible, the effective date of eligibility is determined upon whether the person makes a timely financial contribution to his POWER account.

For HIP Regular Plus or HIP State Plus, coverage begins the first day of the month in which the individual makes an initial POWER account contribution. There is no retroactive coverage under HIP PLUS categories (MARP and MASP).

The effective date of HIP Regular Basic or HIP State Basic coverage begins in the month the member, whose income is at or below 100% FPL, fails to make a required contribution to his POWER account within his sixty (60) day payment period. There is no retroactive coverage under HIP Basic categories (MARB and MASB).

3525.05.00    Fast Track Eligibility (FTE)

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6  405 IAC 10-3-2  
7  405 IAC 10-4-1  
8  405 IAC 10-3-2  
9  405 IAC 10-3-2  
10 405 IAC 10-3-2  

Upon receipt of an application for health coverage but prior to a HIP eligibility determination, a HIP health plan will send the pending HIP applicant a $10 fast track prepayment invoice that is due within sixty (60) calendar days. This initial fast track invoice begins the individual’s 60-day deadline to make a required contribution to a POWER account.

If the applicant makes the $10 fast track payment and is subsequently determined eligible for HIP, the member will have HIP Plus coverage beginning the month the fast track payment was made, and the $10 will be applied toward any remaining amount owed by the member toward their POWER account.

If the applicant who makes the $10 fast track payment is subsequently determined ineligible for HIP, the member is entitled to a refund from the managed care health plan that received the $10 payment. Please, note it may take up to 60 days for the health plan to issue any refund.

If the applicant does not make a $10 fast track payment and is subsequently determined conditionally eligible for HIP, the member will have the option of either paying the $10 fast track prepayment or paying the amount set forth in the conditional eligibility notice.

3525.05.05 Fast Track Eligibility (FTE) with Credit Card

When an application for health coverage is completed on-line, applicants who meet the following conditions will have the option to make the $10 fast track payment on-line with a credit card:

a) A health plan was chosen on the application
b) The applicant is at least 19 years old and is less than 65
c) The applicant is not eligible for Medicare
d) The applicant is not identified as former foster youth
e) The applicant is not incarcerated
f) The applicant does not have a HIP lock-out penalty period in force (refer to 3550.15.00)

If an applicant makes a $10 fast track on-line payment with a credit card and is subsequently determined eligible for HIP, coverage begins the month the payment was made, which would be the month of application, and the $10 will be applied toward any remaining amount owed by the member toward their POWER account. A maximum of 5 individuals on a

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11 405 IAC 10-3-3
12 405 IAC 10-3-3(e)
single application can be eligible for FTE. The Pre-POWER Account Contribution (PPAC) payment of $10 is required for each individual who is eligible for FTE.

If an applicant who makes a $10 fast track on-line payment with a credit card is subsequently determined ineligible for HIP, the member is entitled to a refund from the HIP health plan that received the $10 payment. Please, note it may take up to 60 days for the health plan to issue any refund.

3525.05.10 Fast Track Eligibility and Presumptive Eligibility

If an individual is determined presumptively HIP eligible by a qualified provider, a managed care health plan can send an invoice for a $10 fast track payment to a presumptively eligible member.

A member who is presumptively eligible must submit an application for health coverage to DFR prior to the last day in the month following the PE determination or that person loses their presumptive eligibility. A presumptively eligible member that does submit an application for health coverage within 30 days of being determined presumptively eligible by a qualified provider, will keep his presumptive eligibility coverage until a determination of eligibility is made on his application.

A presumptively eligibility member who makes a $10 fast track payment and is subsequently determined eligible for HIP will have managed care coverage beginning in the following month.

A presumptive eligibility member who fails to make a $10 fast track payment and is subsequently determined conditionally eligible for HIP will have his presumptive eligibility end.

A presumptive eligibility member who makes a $10 fast track payment and is subsequently determined ineligible for HIP will be entitled to a refund that may take up to 60 days for the health plan to issue.

A person cannot receive multiple periods of presumptive eligibility in single twelve (12) month cycle.

3530.00.00 FINANCIAL ELIGIBILITY REQUIREMENTS

The income standards for the HIP program are in Section 3010.30.10.

3530.05.00 INCOME ELIGIBILITY REQUIREMENTS
To be eligible for the HIP program, an individual’s countable household income may not exceed 133 percent of the Federal Poverty Level for the appropriate household size, effective February 1, 2015. Household size and income is determined using Modified Adjusted Gross Income (MAGI) methodology. Refer to Chapter 2800 and Chapter 3200 of the IHCPPM for policy surrounding income and assistance group formation.

3530.05.05 Eligibility Requirements for HIP Low-Income Parent-Caretakers

This section applies to MASP and MASB.

To be considered HIP eligible as a low-income parent/caretaker, the HIP adult must be the parent or caretaker relative (refer to sections 2420.05.05 and 2420.10.05) of a dependent less than 18 years of age and have household income that is equal to or less than the standard set in IHCPPM 3010.30.10.05.

HIP low-income parent/caretakers may be eligible to receive coverage for medical services that were received in the ninety (90) calendar days prior to enrollment in HIP. This will be limited to new applicants, defined as those not covered through HIP or Medicaid within the past two years who:

i. Did not gain coverage through presumptive eligibility;

ii. Received medical care within the 90 days prior to the effective date of eligibility; and

iii. Submitted for reimbursement within 90 days of the individual’s receipt of the bill for such care.

3530.05.10 Eligibility Requirements for HIP TMA

This section applies to MASP and MASB.

To be considered HIP eligible for transitional medical assistance (TMA), the HIP adult must have been financially eligible as a low-income parent/caretaker (refer to Section 3530.05.05) in three of the six months immediately preceding ineligibility as a low-income parent/caretaker due to new or increased earnings. This is also applicable to the adult HIP eligible spouse of someone who qualifies for TMA.

HIP TMA coverage can last up to 12 months. For TMA eligibility periods and reporting requirements, refer to Chapter 3800.
Section 3530.05.15 is applicable to TMA recipients also. If the new earnings do not place a TMA member above 100% FPL, the member will remain eligible under HIP State Basic.

3530.05.15 Eligibility Requirement for Potential Plus

For members eligible under either MASB or MARB who experience a verified change in which the new household income is above 100% FPL, they will be required to switch to either MASP or MARP and will have 60 days to make a required financial contribution to a POWER account.

Members who are required to be switched to MARP and fail to make a timely payment will be discontinued and may be subject to a 6-month penalty period.13 Refer to Section 3550.15.00.

3530.05.20 Eligibility Requirements for HIP Low-Income 19/20 year old

This section applies to MASP and MASB.

To be eligible a child must be either age 19 or 20, live in the home of a parent or caretaker relative, not have Medicare or receive HCBS services, and meet the MAGF income requirements. A parent includes biological, adopted, and step-parents. For the definition of a caretaker relative, please, refer to IHCPPM 2420.00.00

3530.10.00 RESOURCE ELIGIBILITY REQUIREMENTS

There is no resource limit for HIP eligibility.

3540.00.00 POWER ACCOUNT CONTRIBUTION ELIGIBILITY REQUIREMENTS

Most members must make monthly contributions to their POWER account to move from conditional to full eligibility status after initial determination. Members must continue to make these contributions in a timely manner to maintain program enrollment. The following sections discuss the specifics of POWER account contribution requirements.

3540.05.00 POWER ACCOUNT CONTRIBUTION AMOUNT DETERMINATION

All HIP members are initially required to help fund the $2,500 deductible by contributing to the POWER account, established by the member’s health plan and jointly funded

13 405 IAC 10-4-9(f)
by the member and the State, unless the person is an American Indian/Alaska Native.\textsuperscript{14} The amount of the required member contribution is determined based on the person’s countable household income using MAGI methodology. The difference between the amount of the deductible and the member’s annual contribution is paid by the State. If an individual (at or below 100% FPL) does not make the fast track prepayment nor the initial POWER account contribution for HIP Plus, the client will begin HIP Basic or HIP State Plan Basic benefits, as applicable, on the first day of the month in which the sixty (60) day payment period expires.\textsuperscript{15}

A member’s monthly POWER account contribution shall be determined by multiplying a member’s annual household income by two percent (2\%) and dividing by twelve (12). In no event shall the member’s monthly POWER account payment exceed one hundred dollars ($100) per month or be less than one dollar ($1) per month.\textsuperscript{16}

An employer or health care provider or provider-related entity may contribute up to one hundred percent (100\%) of a member’s annual POWER account obligation.\textsuperscript{17} A health care provider or provider-related entity may make a contribution to a member’s POWER account provided:

1) The provider or provider-related entity establishes criteria for providing assistance that do not distinguish between individuals based on whether they receive or will receive services from the contributing provider or providers or class of providers; and

2) The provider or provider-related entity does not include the cost of such payments in either the cost of care for purposes of Medicare or Medicaid cost reporting or as part of a Medicaid shortfall or uncompensated care for any purpose.\textsuperscript{18}

Except for the $1 minimum contribution to a POWER account, a member’s out-of-pocket cost sharing amount shall not exceed five percent (5\%) of the member’s annual household income.\textsuperscript{19} The 5\% maximum contribution value will be calculated by ICES on a quarterly frequency. In the case where two members are married, the combined total of both spouses’ required POWER account contributions cannot exceed two percent (2\%) of the monthly household income, subject to the one dollar ($1)

\begin{itemize}
  \item \textsuperscript{14} 405 IAC 10-10-3
  \item \textsuperscript{15} 405 IAC 10-3-3
  \item \textsuperscript{16} 405 IAC 10-10-3
  \item \textsuperscript{17} 405 IAC 10-10-10
  \item \textsuperscript{18} 405 IAC 10-10-4
  \item \textsuperscript{19} 405 IAC 10-10-3
\end{itemize}
A member’s POWER account under either MASP or MARP may change in accordance with change processing policy when changes are verified.

3545.00.00 CHANGE PROCESSING

HIP members are required to timely notify DFR of any changes. (Refer to sections 2220.05.00 and 2220.10.00). Members receive notice of this requirement through the Rights and Responsibilities portion of their application for health coverage.

An individual who is enrolled into HIP as an eligible member and then becomes pregnant remains HIP eligible, but with additional pregnancy coverage. HIP pregnancy benefits do not require any cost-sharing for services under any HIP category. Refer to Section 2426.00.00. The HIP member may choose to have her eligibility switched prospectively to the pregnancy category, MAGP. Refer to Section 2220.05.00. For pregnant HIP members during redetermination, refer to 3550.10.00.

3545.05.00 POWER ACCOUNT CONTRIBUTIONS IN MULTIPLE-MEMBER HOUSEHOLDS

For households in which two members are enrolled in HIP, each enrollee will have his/her own POWER account. However, for a married couple, the total of both enrollees’ POWER account contributions may not exceed two percent (2%) of the family’s household income as specified in Section 3550.05.00 of this Chapter. This does not apply to unmarried couples.

3545.10.00 POWER ACCOUNT CONTRIBUTIONS AND INITIAL ELIGIBILITY

After an individual meets all eligibility requirements for the HIP program, he or she is “conditionally eligible” until the first POWER account contribution is made to the health plan, unless an FTE payment had already been made (refer to 3525.05.05). If the individual fails to make this initial payment, he or she is no longer conditionally eligible for HIP PLUS. If the individual income is at or below 100% FPL he/she will be enrolled in HIP Basic after failing to make the first POWER account contribution.

The effective date of HIP coverage is the first day of the month in which the health plan receives the first contribution and establishes the member’s POWER account.21

20 405 IAC 10-10-3
21 405 IAC 9-10-6(b)
3545.15.00 POWER ACCOUNT CONTRIBUTIONS AND CONTINUED ELIGIBILITY

Members must continue to make POWER account contributions in a timely manner to remain enrolled in HIP Plus. If an enrollee fails to make a required contribution within 60 days after the due date, he or she will be terminated from HIP Plus. If the individual income is at or below 100% FPL he/she will be enrolled in HIP Basic.

If an individual is dis-enrolled for failing to make a required contribution, he or she will be ineligible for six (6) months.

3550.00.00 HIP REDETERMINATIONS

Sections 2205.00.00, 2205.05.00, 2205.10.00, and 2205.15.00 are applicable to HIP members.

HIP Plus members (MASP or MARP) are required to continue making contributions to their POWER account during their redetermination, and if redetermined eligible for HIP will be re-enrolled as HIP Plus members (MASP or MARP).

HIP TMA recipients are exempt from being required to complete an annual redetermination. Refer to Section 3530.05.10.

3550.05.00 BASIC POTENTIAL PLUS AT REDETERMINATION

Members that are eligible under either MASB or MARB during their annual redetermination and are re-enrolled into HIP with household income less than 100% FPL will have the potential to switch to either MASP or MARP if they make a financial contribution to a POWER account.\(^{22}\)

3550.10.00 PREGNANT HIP MEMBERS AT REDETERMINATION

When it is time for a pregnant HIP member to go through an annual redetermination of eligibility, the pregnant member will automatically be switched to MAGP. Due to her pregnancy, the member is not required to complete the annual redetermination. The switch from HIP to MAGP is to occur automatically upon the woman’s redetermination date.

3555.00.00 LOSS OF ELIGIBILITY

When an eligible HIP recipient loses eligibility for HIP, the member may or may not be subject to a 6-month penalty period depending on the reason for termination. If a member

\(^{22}\) 405 IAC 10-4-9(e)(2); 405 IAC 10-4-9(e)(4)
has eligibility terminated for failing to make a required contribution if over 100% FPL or voluntarily withdrawing from the program, the member will be subject to a 6-month penalty period.\textsuperscript{23} During this time, the individual will not be considered eligible for HIP. Members whose benefits are terminated for other reasons will not be subject to any 6-month penalty.

\textbf{3555.05.00 REASONS FOR LOSS OF ELIGIBILITY}

In addition to the failure to make required POWER account contributions in a timely manner and voluntarily withdrawing,\textsuperscript{24} there are several other reasons a member may lose HIP eligibility within the 12 month coverage period:

(1) The individual is no longer an Indiana resident;

(2) The member is enrolled or is otherwise eligible for enrollment in the federal Medicare program.

(3) The individual becomes eligible for another Medicaid category, except for pregnant women (refer to section 2220.05.00);

(4) The member has household income above one hundred percent (100%) of the FPL and is discontinued for failing to make the required POWER account contributions.

(5) The member or the member's duly authorized representative requests in writing that coverage be terminated (voluntary withdrawal).

(6) The State discovers that the individual has falsified information on the application. In this case, the individual may be held financially responsible for the amount of payments made on his behalf by the State, including POWER account contributions.

(7) The member turns 65 years old.

(8) Except for a member eligible for transitional medical assistance, the member's household income exceeds one hundred thirty-three percent (133%) of the FPL.

(9) The member fails to verify citizenship or immigration status within 95 days of being

\textsuperscript{23} 405 IAC 10-10-12

\textsuperscript{24} 405 IAC 10-10-12
determined eligible for HIP or conditionally
eligible for HIP. (Refer to Sections 2402.15.10 and
2402.20.50).

(10) The member dies.

(11) The member does not complete a redetermination
timely. Refer to Section 3550.10.00.

3555.10.00 LOSS OF ELIGIBILITY AT REDETERMINATION

In order to continue HIP participation, members must complete a
renewal process every 12 months. If the agency is unable to
redetermine the eligibility of the individual with already
available information the member is sent an Eligibility Review
Form. Members who do not follow the renewal process and return
all documentation requested by the agency within 45 days (before
the end of the individual’s 12 month coverage period will be
dis-enrolled.

Closure due to eligibility failure in the month of
redetermination (ex. Over the income limit) is not eligible for
rescission even if circumstances change; a new application would
be required. However, if the closure happened because
correct/complete documentation was not provided, the member
may qualify to have the closure rescinded.

To qualify for rescission of the closure, the member must
comply with returning all needed documentation (including
signature on the redetermination form, if applicable) before
the 90th day after the benefit period ends. A new application
is not required, but the member can only be authorized
conditionally. Fully open HIP will not resume until the
member either pays the first POWER Account payment and opens
in Plus coverage, or waits 60 days and defaults to Basic
coverage. At the end of this 90 day period, a new application
would be required in order for benefits to be reopened.

3555.15.00 SIX MONTH PENALTY PERIOD

When a member is discontinued from HIP eligibility for
either failing to make a required financial contribution
toward a POWER account or voluntarily withdrawing from the
program, the member is subject to a 6-month penalty period, in which the member is ineligible for HIP.\textsuperscript{25} The penalty period will begin the first day of the month following the month the individual was discontinued and will last for 6 months.

3555.15.05 Exceptions to the Six-Month Penalty Period

When a member is subject to a penalty period (refer to Section 3550.15.00), the person may have that penalty period lifted under the following circumstances.

The following exceptions are applicable\textsuperscript{26}:

a) the member is confirmed to be frail;

b) the member obtained and subsequently lost private insurance coverage;

c) the member had a loss of income after disqualification due to increased income;

d) the member took up residence in another state and later returned to Indiana;

e) the member was a victim of domestic violence;

f) the member was residing in a county subject to a disaster declaration made at any time during the sixty (60) calendar days prior to or including the date such member was terminated from the plan;

The following members are exempt from lockout of coverage for any reason. If such a member is closed and reapplies, the system should not show a lockout and no lockout exemption form is required from them to be reselected for coverage and processed as a normal application.

1) Have a current Medically Frail confirmation
2) Pregnant or in the postpartum period
3) Low-Income Parent/Caretakers
4) Verified Native Americans
5) Ryan White program members
6) Are in a Transitional Medical Assistance (TMA) period

3560.00.00 RESERVED

3565.00.00 HIP ID CARDS

\textsuperscript{25} 405 IAC 10-10-12
\textsuperscript{26} 405 IAC 10-10-13
A HIP card will be issued from the assigned managed care health plan **within five (5) calendar days** of a new member’s full enrollment.