HOUSE BILL No. 1163

DIGEST OF INTRODUCED BILL

Citations Affected: IC 12-15-44.5.

Synopsis: Healthy Indiana plan. Removes the requirement from the healthy Indiana plan (HIP) that if an individual who has an annual income of more than 100% of the federal poverty income level has not made payment to HIP within 60 days, the individual shall be terminated from HIP and may not reenroll in HIP for at least six months. (The reduced benefit and copayment requirements that apply to individuals who have an annual income that is at or below 100% of the federal income poverty level would also apply to individuals with an annual income above 100% of the federal poverty income level.) Makes a conforming change.

Effective: July 1, 2019.

Klinker, Campbell

January 8, 2019, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 121st General Assembly (2019)

HOUSE BILL No. 1163

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 12-15-44.5-4.7, AS AMENDED BY P.L.152-2017, SECTION 33, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4.7. (a) To participate in the plan, an individual must apply for the plan on a form prescribed by the office. The office may develop and allow a joint application for a household.

(b) A pregnant woman is not subject to the cost sharing provisions of the plan. Subsections (c) through (g) do not apply to a pregnant woman participating in the plan.

(c) An applicant who is approved to participate in the plan does not begin benefits under the plan until a payment of at least:

(1) one-twelfth (1/12) of the annual income contribution amount; or

(2) ten dollars ($10);

is made to the individual's health care account established under section 4.5 of this chapter for the individual's participation in the plan. To continue to participate in the plan, an individual must contribute to the individual's health care account at least two percent (2%) of the

individual's annual household income per year or an amount determined by the secretary that is based on the individual's annual household income per year, but not less than one dollar ($1) per month. The amount determined by the secretary under this subsection must be approved by the United States Department of Health and Human Services and must be budget neutral to the state as determined by the state budget agency.

(d) If an applicant who is approved to participate in the plan fails to make the initial payment into the individual's health care account, at least the following must occur:

(1) If the individual has an annual income that is at or below one hundred percent (100%) of the federal poverty income level, the individual's benefits are reduced as specified in subsection (e)(1).

(2) If the individual has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual is not enrolled in the plan.

(e) If an enrolled individual's required monthly payment to the plan is not made within sixty (60) days after the required payment date, the ~~following, at a minimum, occur:~~

~~(1) For an~~ individual ~~who has an annual income that is at or below one hundred percent (100%) of the federal income poverty level, the individual is:~~ **shall be:**

~~(A)~~ **(1)** transferred to a plan that has a material reduction in benefits, including the elimination of benefits for vision and dental services; and

~~(B)~~ **(2)** required to make copayments for the provision of services that may not be paid from the individual's health care account.

~~(2) For an individual who has an annual income of more than one hundred percent (100%) of the federal poverty income level, the individual shall be terminated from the plan and may not reenroll in the plan for at least six (6) months.~~

(f) The state shall contribute to the individual's health care account the difference between the individual's payment required under this section and the plan deductible set forth in section 4.5(c) of this chapter.

(g) A member shall remain enrolled with the same managed care organization during the member's benefit period. A member may change managed care organizations as follows:

(1) Without cause:

(A) before making a contribution or before finalizing enrollment in accordance with subsection (d)(1); or

(B) during the annual plan renewal process.

(2) For cause, as determined by the office.

SECTION 2. IC 12-15-44.5-4.9, AS AMENDED BY P.L.114-2018, SECTION 6, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2019]: Sec. 4.9. (a) An individual who is approved to participate in the plan is eligible for a twelve (12) month plan period if the individual continues to meet the plan requirements specified in this chapter.

(b) If an individual chooses to renew participation in the plan, the individual is subject to an annual renewal process at the end of the benefit period to determine continued eligibility for participating in the plan. If the individual does not complete the renewal process, the individual may not reenroll in the plan for at least six (6) months.

(c) This subsection applies to participants who consistently made the required payments in the individual's health care account. If the individual receives the qualified preventative services recommended to the individual during the year, the individual is eligible to have the individual's unused share of the individual's health care account at the end of the plan period, determined by the office, matched by the state and carried over to the subsequent plan period to reduce the individual's required payments. If the individual did not, during the plan period, receive all qualified preventative services recommended to the individual, only the nonstate contribution to the health care account may be used to reduce the individual's payments for the subsequent plan period.

(d) For individuals participating in the plan who, in the past, did not make consistent payments into the individual's health care account while participating in the plan, but:

(1) had a balance remaining in the individual's health care account; and

(2) received all of the required preventative care services;

the office may elect to offer a discount on the individual's required payments to the individual's health care account for the subsequent benefit year. The amount of the discount under this subsection must be related to the percentage of the health care account balance at the end of the plan year but not to exceed a fifty percent (50%) discount of the required contribution.

(e) If an individual is no longer eligible for the plan **or** does not renew participation in the plan at the end of the plan period, ~~or is terminated from the plan for nonpayment of a required payment,~~ the office shall, not more than one hundred twenty (120) days after the last date of the plan benefit period, refund to the individual the amount determined under subsection (f) of any funds remaining in the

individual's health care account as follows:

(1) An individual who is no longer eligible for the plan or does not renew participation in the plan at the end of the plan period shall receive the amount determined under STEP FOUR of subsection (f).

(2) An individual who is ~~terminated from the plan due to nonpayment of a~~ required **to make a** payment **for a nonpayment to the plan** shall receive the amount determined under STEP SIX of subsection (f).

The office may charge a penalty for any voluntary withdrawals from the health care account by the individual before the end of the plan benefit year. The individual may receive the amount determined under STEP SIX of subsection (f).

(f) The office shall determine the amount payable to an individual described in subsection (e) as follows:

STEP ONE: Determine the total amount paid into the individual's health care account under this chapter.

STEP TWO: Determine the total amount paid into the individual's health care account from all sources.

STEP THREE: Divide STEP ONE by STEP TWO.

STEP FOUR: Multiply the ratio determined in STEP THREE by the total amount remaining in the individual's health care account.

STEP FIVE: Subtract any nonpayments of a required payment.

STEP SIX: Multiply the amount determined under STEP FIVE by at least seventy-five hundredths (0.75).