**IC 12-15-44.5**

## Chapter 44.5. Healthy Indiana Plan 2.0

**IC 12-15-44.5-1**

**"Phase out period"**

Sec. 1. As used in this chapter, "phase out period" refers to the following periods:

(1) The time during which a:

(A) phase out plan;

(B) demonstration expiration plan; or

(C) similar plan approved by the United States Department of Health and Human Services;

is in effect for the plan set forth in this chapter.

(2) The time beginning upon the office's receipt of written notice by the United States Department of Health and Human Services of its decision to:

(A) terminate or suspend the waiver demonstration for the plan; or

(B) withdraw the waiver or expenditure authority for the plan;

and ending on the effective date of the termination, suspension, or withdrawal of the waiver or expenditure authority.

(3) The time beginning upon:

(A) the office's determination to terminate the plan; or

(B) the termination of the plan under section 4(b) of this chapter;

if subdivisions (1) through (2) do not apply, and ending on the effective date of the termination of the plan.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-2**

**"Plan"**

Sec. 2. As used in this chapter, "plan" refers to the healthy Indiana plan 2.0 established by section 3 of this chapter.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-3**

**Plan established; eligibility; supercedes conflicting provisions during applicable period; administration; phase out period**

Sec. 3. (a) The healthy Indiana plan 2.0 is established. This chapter is in addition to the provisions set forth in IC 12-15-44.2. For the period beginning February 1, 2015, and ending the date the plan is terminated upon the completion of a phase out period, if a provision in this chapter conflicts with IC 12-15-44.2, this chapter supersedes the conflicting provision in IC 12-15-44.2.

(b) The office shall administer the plan.

(c) The following individuals are eligible for the plan:

(1) An individual who is eligible and described in IC 12-15-44.2-9.

(2) The adult group described in 42 CFR 435.119.

(3) Pregnant women who choose to remain in the plan during the pregnancy.

(4) Parents and caretaker relatives eligible under 42 CFR 435.110.

(5) Low income individuals who are:

(A) at least nineteen (19) years of age; and

(B) less than twenty-one (21) years of age;

and eligible under 42 CFR 435.222.

(6) Individuals, for purposes of receiving transitional medical assistance.

(d) The following individuals are not eligible for the plan:

(1) An individual who participates in the federal Medicare program (42 U.S.C. 1395 et seq.).

(2) Except for an individual described in subsection (c), an individual who is otherwise eligible for medical assistance.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-4**

**Scope of the plan; factors that trigger termination of the plan; implementation of other plan upon termination**

Sec. 4. (a) The plan:

(1) is not an entitlement program; and

(2) serves as an alternative to health care coverage under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(b) If either of the following occurs, the office shall terminate the plan in accordance with section 6(b) of this chapter:

(1) The:

(A) percentages of federal medical assistance available to the plan for coverage of plan participants described in Section 1902(a)(10)(A)(i)(VIII) of the federal Social Security Act are less than the percentages provided for in Section 2001(a)(3)(B) of the federal Patient Protection and Affordable Care Act; and

(B) hospital assessment committee (IC 16-21-10), after considering the modification and the reduction in available funding, does not alter the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in federal medical assistance.

For purposes of this subdivision, "coverage of plan participants" includes payments, contributions, and amounts referred to in IC 16-21-10-13.3(b)(1)(A), IC 16-21-10-13.3(b)(1)(C), and IC 16-21-10-13.3(b)(1)(D), including payments, contributions, and amounts incurred during a phase out period of the plan.

(2) The:

(A) methodology of calculating the incremental fee set forth in IC 16-21-10-13.3 is modified in any way that results in a reduction in available funding;

(B) hospital assessment fee committee (IC 16-21-10), after

considering the modification and reduction in available funding, does not alter the formula established under IC 16-21-10-13.3(b)(1) to cover the amount of the reduction in fees; and

(C) office does not use alternative financial support to cover the amount of the reduction in fees.

(c) If the plan is terminated under subsection (b), the secretary may implement a plan for coverage of the affected population in a manner consistent with the healthy Indiana plan (IC 12-15-44.2) in effect on January 1, 2014:

(1) subject to prior approval of the United States Department of Health and Human Services; and

(2) without funding from the incremental fee set forth in IC 16-21-10-13.3.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-5**

**Responsibilities of an insurer or health maintenance organization that contracts with the office; reimbursement rate; requirement to incorporate cultural competency standards**

Sec. 5. (a) An insurer or health maintenance organization that contracts with the office to provide health insurance coverage, dental coverage, or vision coverage to an individual who participates in the plan:

(1) is responsible for the claim processing for the coverage;

(2) shall reimburse providers at a rate that is not less than the rate established by the secretary. The rate set by the secretary must be based on a reimbursement formula that is:

(A) comparable to the federal Medicare reimbursement rate for the service provided by the provider; or

(B) one hundred thirty percent (130%) of the Medicaid reimbursement rate for a service that does not have a Medicare reimbursement rate; and

(3) may not deny coverage to an eligible individual who has been approved by the office to participate in the plan.

(b) An insurer or a health maintenance organization that contracts with the office to provide health insurance coverage under the plan must incorporate cultural competency standards established by the office. The standards must include standards for non-English speaking, minority, and disabled populations.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-6**

**Phase out funds deposited from incremental hospital assessment fees; notice and phase out if plan is terminated**

Sec. 6. (a) For:

(1) the state fiscal year beginning July 1, 2016, through the state fiscal year beginning July 1, 2019, fees totaling eleven million five hundred thousand dollars ($11,500,000) from incremental

fees collected under IC 16-21-10-13.3 shall be deposited annually into the phase out trust fund established under section 7 of this chapter; and

(2) the state fiscal years beginning July 1, 2020, and thereafter, the hospital assessment fee committee (IC 16-21-10), after consulting with the office and the Indiana Hospital Association, shall determine the amount of fees to be deposited into the phase out trust fund for the state fiscal year to augment the balance of the trust fund at a projected amount, subject to amounts that would be available under IC 12-15-44.2-17 and funds previously deposited into the phase out trust fund under this subsection that are necessary to cover the state share of the expenses described in IC 16-21-10-13.3(b)(1)(A) through IC 16-21-10-13.3(b)(1)(F) for a twelve (12) month period.

The phase out funds shall be deposited into the phase out trust fund established in section 7 of this chapter from the incremental fee collected under IC 16-21-10-13.3.

(b) If the plan is to be terminated for any reason, the office shall:

(1) if required, provide notice of termination of the plan to the United States Department of Health and Human Services and begin the process of phasing out the plan; or

(2) if notice and a phase out plan is not required under federal law, notify the hospital assessment fee committee (IC 16-21-10) of the office's intent to terminate the plan and the plan shall be phased out under a procedure approved by the hospital assessment fee committee.

The office may not submit any phase out plan to the United States Department of Health and Human Services or accept any phase out plan proposed by the Department of Health and Human Services without the prior approval of the hospital assessment fee committee.

(c) Before submitting:

(1) an extension of; or

(2) a material amendment to;

the plan to the United States Department of Health and Human Services, the office shall inform the Indiana Hospital Association of the extension or material amendment to the plan.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-7**

**Phase out trust fund established; purpose of the fund; uses; administration; fund is considered a trust fund**

Sec. 7. (a) The phase out trust fund is established for the purpose of holding the money needed during a phase out period of the plan. Funds deposited under this section shall be used only:

(1) to fund the state share of the expenses described in IC 16-21-10-13.3(b)(1)(A) through IC 16-21-10-13.3(b)(1)(F) incurred during a phase out period of the plan;

(2) after funds from the healthy Indiana trust fund (IC 12-15-44.2-17) are exhausted; and

(3) to refund hospitals in the manner described in subsection (h).

The fund is separate from the state general fund.

(b) The fund shall be administered by the office.

(c) The expenses of administering the fund shall be paid from money in the fund.

(d) The trust fund must consist of:

(1) the funds described in section 6 of this chapter; and

(2) any interest accrued under this section.

(e) The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public money may be invested. Interest that accrues from these investments shall be deposited in the fund.

(f) Money in the fund does not revert to the state general fund at the end of any fiscal year.

(g) The fund is considered a trust fund for purposes of IC 4-9.1-1-7. Money may not be transferred, assigned, or otherwise removed from the fund by the state board of finance, the budget agency, or any other state agency unless specifically authorized under this chapter.

(h) At the end of the phase out period, any remaining funds and accrued interest shall be distributed to the hospitals on a pro rata basis based on the fees authorized by IC 16-21-10 that were paid by each hospital for the state fiscal year that ended immediately before the beginning of the phase out period.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-8**

**Requirements for use of money appropriated to the fund; requirements for use of the incremental hospital assessment fee; payment for health care services; administrative costs; profit**

Sec. 8. The following requirements apply to funds appropriated by the general assembly to the plan and the incremental fee used for purposes of IC 16-21-10-13.3:

(1) At least eighty-seven percent (87%) of the funds must be used to fund payment for health care services.

(2) An amount determined by the office of the secretary to fund:

(A) administrative costs of; and

(B) any profit made by;

an insurer or a health maintenance organization under a contract with the office to provide health insurance coverage under the plan. The amount determined under this subdivision may not exceed thirteen percent (13%) of the funds.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-9**

**Rules**

Sec. 9. (a) The office may adopt rules under IC 4-22-2 necessary to implement:

(1) this chapter; or

(2) a Section 1115 Medicaid demonstration waiver concerning the plan that is approved by the United States Department of Health and Human Services.

(b) The office may adopt emergency rules under IC 4-22-2-37.1 to implement the plan on an emergency basis.

(c) An emergency rule or an amendment to an emergency rule adopted under this section expires not later than the earlier of:

(1) one (1) year after the rule is accepted for filing under IC 4-22-2-37.1(e); or

(2) July 1, 2016.

*As added by P.L.213-2015, SEC.136.*

**IC 12-15-44.5-10**

**Authorized changes to the plan**

Sec. 10. The secretary may make changes to the plan under this chapter if the changes are required by one (1) of the following:

(1) The United States Department of Health and Human Services.

(2) Federal law or regulation.

*As added by P.L.213-2015, SEC.136.*