IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS BT201506 FEBRUARY 3, 2015

# Pregnancy-related services covered under HIP

As announced in *Indiana Health Coverage Programs (IHCP) Provider Bulletin* BT201503, the Indiana Family and Social Services Administration (FSSA) is implementing the new Healthy Indiana Plan (HIP) program. The new HIP program serves nondisabled low-income adults ages 19-64 with incomes at or below 133% of the federal poverty level (FPL).[1] The new HIP includes coverage for maternity services and enhanced benefits for pregnant women. HIP-eligible pregnant women, including those formerly served in Hoosier Healthwise, will be enrolled in the plan options described in this bulletin beginning February 1, 2015. Enrollment and coverage options for HIP-eligible pregnant women are as follows.

### Coverage for pregnant women transitioning from Hoosier Healthwise to HIP

Pregnant women transitioning from Hoosier Healthwise to HIP will be automatically enrolled as *HIP Maternity* members during their pregnancy. Coverage under *HIP Maternity* provides Package A benefits as are provided under Hoosier Healthwise. There are no cost-sharing obligations for *HIP Maternity* coverage. *HIP Maternity* members will transition to one of the HIP benefit plans at the conclusion of their pregnancy, after a 60-day postpartum period.

### Coverage for HIP-eligible women who are pregnant when they apply

HIP-eligible women who are pregnant when they apply for coverage will be enrolled as *HIP Maternity* members. *HIP Maternity* coverage provides Package A benefits with no cost-sharing obligations. *HIP Maternity* members will transition to one of the HIP benefit plans at the conclusion of their pregnancy, after a 60-day postpartum period.


### Coverage for women who become pregnant while enrolled in HIP

Women who become pregnant while enrolled in a HIP plan will have all cost-sharing obligations suspended and will receive enhanced benefits for the duration of their pregnancy. The enhanced benefits include access to nonemergency transportation as well as vision and dental services regardless of the HIP benefit plan in which they are enrolled. Enhanced benefits ensure that HIP-enrolled pregnant women have access to the same benefits as pregnant women otherwise enrolled with Package A benefits.

Women should report their pregnancies to their health plan or to the Division of Family Resources (DFR) at 1-800-403-0864 to receive enhanced benefits and have HIP cost sharing suspended. In all HIP benefit plans, maternity services are not subject to the deductible or cost sharing, regardless of whether the woman has reported her pregnancy. HIP administrators will regularly review claims history to ensure cost sharing is suspended and additional benefits are activated for any member who becomes pregnant. Notification of Pregnancy requirements and associated provider incentives are the same under HIP as they are under Hoosier Healthwise. These requirements and incentives do not vary by program.

[1] Income limit for HIP is 133% of the FPL plus a 5% disregard, which is approximately equivalent to an income limit of 138% FPL.

Per federal requirements, pregnant women enrolled in any HIP benefit plan may choose to transition to *HIP Maternity* coverage at any point during their pregnancy. This option is available even though benefits provided through *HIP Maternity* are the same as those available under the enhanced benefit coverage offered to pregnant women under the HIP plan options. Regardless, pregnant women receive comprehensive coverage without the obligation of any cost sharing.

### Coverage for HIP members who are pregnant at the time of eligibility redetermination

Women enrolled in HIP who are pregnant during their regularly scheduled eligibility redetermination will automatically transition to *HIP Maternity* coverage. If a woman is in her 60-day postpartum period during redetermination, she may choose to continue enrollment in her existing HIP benefit plan rather than transitioning to *HIP Maternity*.

### Enrolling in HIP at the conclusion of *HIP Maternity* coverage

Women enrolled in *HIP Maternity* may transition to coverage under a HIP benefit plan at the end of their 60-day postpartum period. To ensure a seamless transition without a gap in coverage, the end of the pregnancy should be reported promptly to the member's health plan. Once the end of the pregnancy has been reported, a *HIP Maternity* member will receive information and an invoice for her *HIP Plus* Personal and Wellness Responsibility (POWER) Account contribution. Payment of this invoice will ensure that coverage under *HIP Plus* will begin as soon as the 60-day postpartum period has concluded under *HIP Maternity*. *HIP Plus* provides coverage without applying copayments as long as members make their monthly contributions to their POWER Accounts. If the *HIP Maternity* member returning to HIP does not make her initial POWER Account contribution for her HIP services and her income is under 100% of the FPL, she will be enrolled in *HIP Basic*, where copayments apply for all services. *HIP Maternity* members need to report the end of their pregnancy promptly to ensure they transition to coverage under a HIP benefit plan without risking a coverage gap or being required to reapply for the program.

**QUESTIONS?**

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