ARKANSAS DEPARTMENT OF HUMAN SERVICES

Health Insurance Premium Payment (HIPP)

I. Introduction: The Arkansas Division of Medical Services (DMS) may pay for health insurance premiums for Medicaid eligible individuals if such payments are cost effective. This chapter contains the rules governing premium payments under the Arkansas Health Insurance Premium Payment (HIPP) program.

II. Definitions

a. Cost Effectiveness: Health insurance premium payments are cost effective if the premiums, coinsurance, deductibles and other cost sharing obligations under a health plan, plus an amount for administrative costs are likely to be less than the amount paid for equivalent Medicaid services. HIPP is **not** cost effective when:

(1) Private insurance premiums are used to meet a spend down obligation under the medically needy program;

(2) The client's eligibility category is "aged."Covered Benefits: Medical assistance as defined in § 1905 of the Social Security Act that is covered under the State Medicaid Plan and any additional services covered under a waiver approved by the Secretary of the Department of Health and Human Services.

b. Equivalent Services: Health care treatment and services that correspond with covered benefits.

c. Family Members: DMS may choose to enroll family members into the health plan who are not Medicaid eligible if cost effective. For Medicaid ineligible family members, DMS covers payment only for the premiums. Other cost sharing expenses are not covered. The family member may reside in a different household.

d. Group Health Plan: Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of employees or former employees. A group health plan must meet S. 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Services Act, S. 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974.

e. Health Plan: Any health insurance plan that, in exchange for premiums paid pays benefits for medical services. Medicare Part B premiums are excluded.

f. HIPP: The Health Insurance Premium Payment program.

g. MMIS: The Medicaid Management Information System.

h. Premium Cost: The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Arkansas's costs being based on "per client" data instead of "per eligible" data.

III. HIPP program: DMS may cover payment of premiums for Medicaid beneficiaries enrolled in a cost effective health plan. DMS may also cover payment of deductibles, co-insurance, and other cost sharing obligations under the health plan if the services are included in the State Plan and provided to a Medicaid beneficiary.

IV. Medicaid Eligibility Unaffected:

a. Enrollment in a health plan does not change the client's eligibility for Medicaid benefits. If services covered under Medicaid are not covered by the health plan, payment for those services is made according to the applicable Medicaid payment methodology. If the client's health plan offers more services than covered under Medicaid, DMS does not pay for the deductibles, coinsurance, and other cost sharing obligations for those non-covered services.

b. Medicare Enrollment: If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, DMS does not pay for the premiums or cost sharing obligations to the health plan unless cost effective.

c. Medicaid Cost Sharing Amounts: If the client is required to pay Medicaid cost sharing amounts, payment of the cost sharing amounts is not covered by the HIPP Program.

V. Third Party Liability: The health plan is considered to be a third party that is legally liable for the payment of care and services provided under the State Medicaid Plan.

VI. Enrollment:

a. Health plans usually limit an individual's enrollment period. If an individual who is already enrolled in a health plan becomes Medicaid eligible, DMS may cover premium payments as of the effective date of Medicaid eligibility.

b. Effective Date of Benefit: If a client is not eligible for coverage under a health plan for a specified waiting period, DMS may cover the premium as of the effective date of eligibility for the health plan. Until the client is eligible to enroll or entitled to receive services under the health plan, all Medicaid-covered services are covered and paid under the usual Medicaid policies and procedures.

c. Delayed Enrollment: If the availability for enrollment in the health plan and eligibility for Medicaid do not coincide, the client/applicant shall apply for HIPP eligibility. The client/applicant will be enrolled in the health plan when eligible if still cost effective.

d. Annual Renewal: Cost effectiveness shall be reviewed at least annually. At least 6 months of claims or EOBs will be reviewed during the renewal period. The annual renewal may coincide with the employer's open enrollment period for employer sponsored plans.

VII. Cost Effectiveness Determination: DMS determines the cost effectiveness of health plans using the following methodology:

a. The Medicaid client furnishes information on the health plan to DMS. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the policy owners.

b. Using the Medicaid Management Information System (MMIS), DMS obtains the total 12 month estimated average inflation-adjusted Medicaid costs for persons comparable to the client with respect to age, sex, and category data.

c. DMS:

(1) Determines (if historical data is available) or estimates (if historical data is unavailable) the total 12 months Medicaid expenditures for covered services (estimated average Medicaid cost);

(2) Identifies equivalent services covered by the private insurance;

(3) Identifies the premium cost;

(4) Determines the cost of any covered services for which the private insurance does not provide equivalent coverage;

(5) Estimates the cost of coinsurance and deductibles up to the Medicaid allowable amounts; and

(6) Determines the administrative cost to Medicaid for processing the health plan information by determining the average increase in cost per client for at least a 12 month Period.

(7) DMS determines the cost of HIPP by adding the amounts identified in § (c)(3)-(6) and compares that cost to the estimated average Medicaid costs. If the cost of the HIPP case is less than the estimated average Medicaid costs, the health plan is cost effective. If the cost of the HIPP case is equal to or greater than the estimated average Medicaid costs, the health plan is not cost effective.

VIII. Exceptional Medical Costs (Special Conditions): If the client provides documentation of on-going medical costs or future medical costs that exceed the estimated average Medicaid costs, DMS may determine that the health plan is cost effective.

IX. Balance Billing: DMS pays only up to the Medicaid allowable amount. For example, if a provider bills $50 for a service and the insurer pays $40, but the Medicaid allowable is $37, Medicaid will not make up the $10 difference between the billed amount and the insurance payment; NOR CAN THE PROVIDER BILL THE CLIENT for the difference. If the provider bills $50 and the insurance pays $37 and the Medicaid allowable is $40, Medicaid can pay the difference, up to the Medicaid allowable - in this case, Medicaid pays $3. In both examples, THE PROVIDER CANNOT BILL THE CLIENT FOR THE DIFFERENCE BETWEEN THE MEDICAID PAYMENT AND THE BILLED AMOUNT.

X. Payment for Services:

a. DMS will pay the health insurance premium directly to the policyholder or designated party through premium payment from payroll deduction or individual plans.

b. DMS will reimburse the policyholder or the financially responsible party for the payroll deduction made for health insurance premiums, and for coinsurance and deductibles subject to the limitations in § IX.