

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 30 - HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 to 68-991 (the Medical Assistance Act). The Health Insurance Premium Payment (HIPP) Program is authorized under §§1905 and 1906 of the Social Security Act.

002. DEFINITIONS. The following definitions apply:

002.01 COST EFFECTIVENESS. A determination, made by the Department, that payment for coverage under a group health plan or individual market health plan will be less than the amount of expenditures under the Nebraska Medicaid State Plan that Medicaid would have made to provide comparable coverage for the client.

002.02 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.

002.03 INDIVIDUAL MARKET HEALTH PLAN. Individual market is the market for health insurance coverage offered to individuals other than in connection with a group health plan. For purposes of the Health Insurance Premium Payment (HIPP) Program, individual market policies include health plans that comply with the requirements of the Patient Protection and Affordable Care Act of 2010 (ACA) and may include policies that do not meet all Affordable Care Act (ACA) requirements but are still found to provide comprehensive health coverage as determined by the Department.

003. PARTICIPATION IN THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM.

003.01 VOLUNTARY PARTICIPATION IN HEALTH INSURANCE PREMIUM PAYMENT (HIPP). Participation in the Health Insurance Premium Payment (HIPP) Program is voluntary. For Medicaid eligible clients, enrollment in the Health Insurance Premium Payment (HIPP) Program does not change the client's eligibility for benefits through the state plan or cost sharing obligations under the state plan.

003.02 PARTICIPATION DETERMINATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP).

003.02(A) REQUIRED DOCUMENTATION. The Department may request any documentation from the client that it deems to be necessary to determine whether the client's enrollment in an available group health

plan or individual market health plan is cost effective. Documentation that must be submitted includes, but is not limited to:

- (i) Signed application for enrollment in the Health Insurance Premium Payment (HIPP) Program;
- (ii) Summary of covered benefits from the group health plan or individual market health plan;
- (iii) If applicable, verification of the client's ongoing medical diagnosis. Verification must be provided by an appropriate physician or entity;
- (iv) Completed verification form for employer sponsored insurance; and
- (v) Monthly proof of health insurance premium payments.

003.03 EFFECTIVE DATE OF PARTICIPATION IN THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM. The effective date for Health Insurance Premium Payment (HIPP) participation is the first day of the month that the following criteria are met:

- (A) The client is enrolled in a group health plan or individual market health plan;
- (B) All documentation necessary for Medicaid to determine cost effectiveness has been submitted; and
- (C) The Department has determined that the client's participation in Health Insurance Premium Payment (HIPP) would be cost effective.

003.04 COST-EFFECTIVENESS DETERMINATION. The Department determines the cost-effectiveness for payment of qualifying group health insurance or individual market health insurance premiums.

003.04(A) COST-EFFECTIVE MEDICAL CONDITIONS. Any Medicaid-eligible client who has an existing, ongoing, medically confirmed medical condition determined by the Department to be considered a cost-effective condition, is deemed to meet the cost-effective criteria.

003.04(B) COST-EFFECTIVENESS CALCULATION. When the criteria of 471 Nebraska Administrative Code (NAC) 30-003.03(A) are not met, cost-effectiveness will be calculated as follows:

- (i) Determine the annual anticipated cost for Medicaid services generally covered by the private health insurance based on the client's age, sex, and eligibility category;
- (ii) Total the results of each of the following calculations:

(1) The portion of the group health insurance or individual market health insurance premium payable by the Health Insurance Premium Payment (HIPP) program;

(2) A predetermined annual administration cost per participant; and

(3) The expected cost to Medicaid for any deductibles, coinsurance, or copayments.

(iii) Subtract the result of (ii) from the result of (i);

(iv) If the result is greater than or equal to \$10, the policy would be determined cost effective; and

(v) If the result is less than \$10, the policy would not be considered cost effective.

003.04(C) SUPPLEMENTAL INFORMATION. When the criteria of 471 NAC 30-003.04(A) and 471 NAC 30-004.03(B) are not met, specific information relating to the individual circumstances of the Medicaid-eligible client may be provided. On a case-by-case basis and at the sole discretion of the Department, a determination of cost effectiveness can be made if sufficient evidence is provided to demonstrate savings to Medicaid.

003.04(D) EXCLUDED CASES. The Department will not make a determination of cost effectiveness in the following circumstances:

(i) The client is eligible for or enrolled in Medicare;

(ii) Payment of health insurance premiums have been fully reimbursed or offset by a third party, including, but not limited to:

(1) An employer; or

(2) An individual court-ordered to provide medical support.

(iii) The recipient is only eligible for a medically needy, spend-down, program; or

(iv) The group health insurance or individual market health insurance only provides catastrophic, limited benefit, limited duration, or indemnity coverage.

003.04(E) MULTIPLE POLICIES. When more than one group or individual market health insurance policy is available, the Department shall pay only for the most cost-effective policy.

003.04(E)(i) EXCEPTION FOR SUPPLEMENTAL POLICIES. At the sole discretion of the Department, in the circumstance when an additional supplemental policy is available and that policy is found to

provide coverage that does not duplicate coverage included in the primary health insurance plan, the Department may include both the primary health plan and supplemental policy in its cost-effectiveness calculation. If the Department finds that paying the costs described in 471 NAC 30-003.04 for both the primary and supplemental health policies is more cost effective than paying solely for the costs of the primary health policy, the Department may pay for the costs of both the primary and supplemental health policies.

003.04(F) REDETERMINATIONS.

003.04(F)(i) ANNUAL REDETERMINATION. The Department conducts a redetermination of participation annually for all clients enrolled in the Health Insurance Premium Payment (HIPP) Program. This redetermination includes:

- (1) Verification of eligibility for Medicaid; and
- (2) Completion of the cost-effective calculation as outlined in 471 NAC 30-004.03(A) through 30-004.03(C).

003.04(F)(ii) CHANGES IN CIRCUMSTANCES. A redetermination of participation may be conducted at any point if:

- (1) The monthly premium of the group health insurance or individual market health insurance increases by more than \$50;
- (2) There is a change in eligibility category or status for Medicaid;
- (3) The services offered by the group health insurance or individual market health insurance decrease;
- (4) There is a change in the deductible, co-insurance, or any other cost-sharing provisions of the group health policy or individual market health policy; or
- (5) There is reason to believe a change has occurred which may affect participation for Health Insurance Premium Payment (HIPP) enrollment.

The client has an affirmative obligation to report any change in circumstances.

003.05 TERMINATION OF HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PARTICIPATION. Failure to provide requested documentation in accordance with 471 NAC 30-003.02(A), or failure to meet Health Insurance Premium Payment (HIPP) enrollment participation criteria as outlined in 471 NAC 30-004.01 and 30-004.03, may result in termination of participation in the Health Insurance Premium Payment (HIPP) Program.

004. REIMBURSEMENTS. Medicaid covers reimbursement of premiums for Medicaid-eligible enrollees in a cost effective group health plan or individual market health plan. Medicaid also covers payment of all deductibles, coinsurance, and other cost sharing obligations under the group health plan or individual market health plan that are for services covered under the Medicaid State Plan.

Reimbursements will be made directly to the policyholder as a reimbursement for the group health insurance or individual market health insurance premiums. The client or policyholder must submit accompanying documentation within sixty days of the date paid showing the premium payment has been made.

004.01 FAMILY MEMBERS. If a family member who is not eligible for Medicaid must be enrolled in the group health plan or individual market health plan to obtain coverage under the group health plan or individual market health plan for the Medicaid-eligible client, Medicaid covers payment for the group health plan premiums for the family member who is not eligible for Medicaid.

004.02 DEDUCTIBLES, COINSURANCE, AND OTHER COST SHARING. The Department will pay deductibles, co-insurance, and cost sharing obligations up to the Medicaid allowable amounts directly to the enrolled Medicaid provider. The provider must submit a claim to the Department in accordance with claim submission and payment guidelines outlined in 471 NAC Chapters 2 and 3, as well as any submission and payment guidelines included within each service specific NAC Title 471 Chapter directly. Payment will be made directly to the provider in an amount up to, but not exceeding, the Medicaid allowable amount less any payment made to the provider by the group health plan or individual market health plan. The provider must accept Medicaid payment as payment in full, and cannot bill the client for the difference between the Medicaid payment and the billed amount.

Prior to submitting a claim to the Department for payment, the provider must complete the provider enrollment process outlined in 471 NAC Chapter 2 as well as any enrollment requirements included within each service specific NAC Title 471 Chapter.

004.02(A) FAMILY MEMBERS. Medicaid does not cover deductibles, coinsurance, and other cost sharing obligations under the group health plan or individual market health plan for any family member who is not eligible for Medicaid.

004.03 SERVICES COVERED BY MEDICAID. A client's enrollment in a group health plan or individual market health plan does not change the client's eligibility for benefits under Medicaid. If services covered under Medicaid are not covered by the group health plan or individual market health plan, the client may obtain these services from Medicaid-enrolled providers. Coverage of, and payment for those services is made according 471 NAC Chapters 1, 2, and 3, as well as any coverage and payment requirements included within each service specific NAC Title 471 Chapter. If

a client is enrolled in Managed Care to obtain services, the coverage and subsequent payment for those services will be in accordance with the Managed Care entities' coverage and payment guidelines.

004.04 SERVICES NOT COVERED BY MEDICAID. Medicaid does not pay for the deductibles, coinsurance, and other cost sharing obligations for services covered under the client's group health plan or individual market health plan that are not covered under the Nebraska Medicaid State Plan.

004.05 MEDICARE ENROLLMENT. If the client is also eligible for Medicare but is not enrolled in Medicare, Medicaid does not pay for the premiums or other cost sharing obligations to the group health plan or individual market health insurance.

005. CLIENTS RIGHT TO APPEAL. The Health Insurance Premium Payment (HIPP) Program is intended to serve as a cost saving measure for Medicaid, and does not confer any additional benefits upon the client. Accordingly, the client does not have the right to appeal an adverse decision regarding enrollment or participation in the Health Insurance Premium Payment (HIPP) Program.

