

1 CABINET FOR HEALTH AND FAMILY SERVICES

2 Department for Medicaid Services

3 Division of Program Integrity

4 (New Administrative Regulation)

5 907 KAR 5:005. Health insurance premium payment (HIPP) program.

6 RELATES TO: 42 USC 1396e(a) through (e)

7 STATUTORY AUTHORITY: KRS 194A.010(1), 194A.030(2), 194A.050(1),

8 205.520(3), 205.560(2), 42 USC 1396e(a) through (e).

9 NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family
10 Services, Department for Medicaid Services has responsibility to administer the
11 Medicaid program. KRS 205.520(3) authorizes the cabinet, by administrative regulation,
12 to comply with a requirement that may be imposed, or opportunity presented by federal
13 law for the provision of medical assistance to Kentucky's indigent citizenry. This
14 administrative regulation establishes the department's health insurance premium
15 payment, or HIPP, program provisions as authorized by 42 USC 1396e(a) through (e).
16 The HIPP program is designed to provide health insurance coverage outside of
17 Medicaid to Medicaid enrollees, and any family member of Medicaid enrollees if cost
18 effective, if the department determines that HIPP program participation would be cost
19 effective for the department.

20 Section 1. Definitions. (1) "Buying in" means purchasing benefits from Medicare on
21 behalf of an individual.

- 1 (2) "Department" means the Department for Medicaid Services or its designee.
- 2 (3) "Federal financial participation" is defined in 42 CFR 400.203.
- 3 (4) "Group health insurance plan" means any plan:
- 4 (a) Of, or contributed to by, an employer – including a self-insured plan – to
- 5 provide health care directly or otherwise to the employer's employees, former
- 6 employees, or the families of the employees or former employees; and
- 7 (b) Which:
- 8 1. Meets criteria established in Section 5000(b)(1) of the Internal Revenue Code of
- 9 1986, as amended, and
- 10 2. Includes continuation coverage pursuant to:
- 11 a. Title XXII of the Public Health Service Act, section 4980B of the Internal Revenue
- 12 Code of 1986; or
- 13 b. Title VI of the Employee Retirement Income Security Act of 1974, as amended.
- 14 (5) "Health insurance premium payment program participant" or "HIPP program
- 15 participant" means an individual receiving health insurance benefits in accordance with
- 16 this administrative regulation.
- 17 (6) "Income" means:
- 18 (a) Wages, salary, or compensation for labor or services;
- 19 (b) Money received from a statutory benefit including Social Security, Veteran's
- 20 Administration pension, black lung benefit, or railroad retirement benefit; or
- 21 (c) Money received from any pension plan, rental property, or an investment including
- 22 interest or dividends.
- 23 (7) "Income deduction" means a deduction from an individual's income for the

1 purpose of obtaining or trying to obtain Medicaid eligibility.

2 (8) "Medicaid" means the Kentucky Medicaid program.

3 (9) "Medicaid enrollee" means an individual eligible for and participating in Medicaid
4 pursuant to 907 KAR 1:011, 907 KAR 1:605, 907 KAR 1:640, and 907 KAR 1:645.

5 (10) "Spend-down program" means a program by which an individual becomes
6 eligible for Medicaid benefits:

7 (a) By spending down income in excess of the Medicaid income threshold; and

8 (b) In accordance with 907 KAR 1:640.

9 (11) "State plan" is defined in 42 CFR 430.10

10 (12) "Wrap-around coverage" means coverage of a benefit not covered by an
11 individual's group health insurance plan.

12 Section 2. HIPP Program Eligibility and Enrollment. (1) A Medicaid enrollee, or a
13 person acting on the Medicaid enrollee's behalf, shall cooperate in providing information
14 to the department necessary for the department to establish availability and cost
15 effectiveness of a group health insurance plan by:

16 (a) Completing the Application for Health Insurance Premium Payment (HIPP)
17 Program, Form PA 41; and

18 (b) Submitting the Application for Health Insurance Premium Payment (HIPP)
19 Program, Form PA 41 to the individual's local Department for Community Based
20 Services office.

21 (2) If a Medicaid enrollee HIPP program applicant, participant, parent, guardian, or
22 caretaker fails to provide information to the department, within ten (10) days of the
23 department's request, necessary to determine availability and cost effectiveness of a

1 group health insurance plan, the department shall not enroll the applicant in the HIPP
2 program unless good cause for failure to cooperate is demonstrated to the department
3 within thirty (30) days of the department's denial.

4 (3) Good cause for failure to cooperate shall be limited to the following circum-
5 stances:

6 (a) A serious illness or death of the applicant, participant, parent, guardian, or
7 caretaker or of a member of the applicant's, participant's, parent's, guardian's, or
8 caretaker's family occurred;

9 (b) A family emergency or household disaster – for example a fire, tornado, flood, or
10 similar;

11 (c) The applicant, participant, parent, guardian, or caretaker demonstrates that
12 a good cause beyond the applicant's participant's parent's guardian's, or
13 caretaker's control occurred; or

14 (d)1. Failure to receive the department's request for information or notification for a
15 reason not attributable to the applicant, participant, parent, guardian, or caretaker
16 occurred.

17 2. Lack of a forwarding address shall be attributable to the applicant, participant,
18 parent, guardian, or caretaker.

19 (4) For a Medicaid enrollee who is a HIPP program participant:

20 (a) The department shall pay all group health insurance plan premiums and
21 deductibles, coinsurance and other cost-sharing obligations for items and services
22 otherwise covered under Medicaid; and

23 (b)1. The individual's group health insurance plan shall be the primary payer; and

1 2. The department shall be the payer of last resort.

2 (5) For a HIPP program participating family member who is not a Medicaid enrollee:

3 (a) The department shall pay a HIPP program premium; and

4 (b) Not pay a deductible, coinsurance or other cost-sharing obligation.

5 (6) If an individual who was a Medicaid enrollee at the time the department initiated a

6 HIPP program cost effectiveness review for the individual loses Medicaid eligibility by

7 the time the cost effectiveness review has been conducted, the department shall not

8 enroll the individual or any family member into the HIPP program.

9 Section 3. Wrap-around Coverage. (1) If a service to which a health insurance

10 premium payment program participant would be entitled via Medicaid is not

11 provided by the individual's group health insurance plan, the department shall reimburse

12 for the service.

13 (2) For a service referenced in subsection (1) of this section, the department

14 shall reimburse:

15 (a) The provider of the service; and

16 (b) In accordance with the department's administrative regulation governing

17 reimbursement for the given service. For example, a wrap-around dental

18 service shall be reimbursed in accordance with 907 KAR 1:626.

19 Section 4. Cost Effectiveness. (1) Enrollment in a group health insurance plan

20 shall be considered cost effective when the cost of paying the premiums, coinsurance,

21 deductibles and other cost-sharing obligations, and additional administrative costs is

22 estimated to be less than the amount paid for an equivalent set of Medicaid services.

23 (2) When determining cost effectiveness of a group health insurance plan, the

1 department shall consider the following information:

2 (a) The cost of the insurance premium, coinsurance, and deductible;

3 (b) The scope of services covered under the insurance plan, including exclusions for
4 pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits
5 imposed;

6 (c) The average anticipated Medicaid utilization:

7 1. By age, sex, and coverage group for persons covered under the insurance plan;

8 and

9 2. Using a statewide average for the geographic component;

10 (d) The specific health-related circumstances of the persons covered under the
11 insurance plan; and

12 (e) Annual administrative expenditures of an amount determined by the department
13 per Medicaid participant covered under the group health insurance plan.

14 Section 5. Cost Effectiveness Review. (1) The department shall complete a cost
15 effectiveness review:

16 (a) At least once every six (6) months for an employer-related group health
17 insurance plan; or

18 (b) Annually for a non-employer-related group health insurance plan.

19 (2) The department shall perform a cost effectiveness re-determination if:

20 (a) A predetermined premium rate, deductible, or coinsurance increases;

21 (b) Any of the individuals covered under the group health insurance plan lose full
22 Medicaid eligibility; or

23 (c) There is a:

- 1 1. Change in Medicaid eligibility;
- 2 2. Loss of employment when the insurance is through an employer; or
- 3 3. A decrease in the services covered under the policy.

4 (3)(a) A health insurance premium payment program participant who is a Medicaid
5 enrollee, or a person on that individual's behalf, shall report all changes concerning
6 health insurance coverage to the participant's local Department for Community Based
7 Services (DCBS), Division of Family Support within ten (10) days of the change.

8 (b) Except as allowed in subsection (4) of this section, if a Medicaid enrollee who is a
9 health insurance premium payment program participant fails to comply with paragraph
10 (a) of this subsection, the department shall disenroll the HIPP program participating
11 Medicaid enrollee, and any family member enrolled in the HIPP program directly
12 through the individual if applicable, from the HIPP program.

13 (4) The department shall not disenroll an individual from HIPP program
14 participation if the individual demonstrates to the department, within thirty (30) days of
15 notice of HIPP program disenrollment, good cause for failing to comply with subsection
16 (3) of this section.

17 (5) Good cause for failing to comply with subsection (3) of this section shall exist if:

18 1. There was a serious illness or death of the individual, parent, guardian, or
19 caretaker or a member of the individual's, parent's guardian's, or caretaker's family;

20 2. There was a family emergency or household disaster – for example a fire, flood,
21 tornado, or similar;

22 3. The individual, parent, guardian, or caretaker offers a good cause beyond the
23 individual's, parent's, guardian's, or caretaker's control; or

1 4.a. There was a failure to receive the department's request for information or
2 notification for a reason not attributable to the individual, parent, guardian, or caretaker.

3 b. Lack of a forwarding address shall be attributable to the individual, parent,
4 guardian, or caretaker.

5 Section 6. Coverage of Non-Medicaid Family Members. (1) If determined to be cost
6 effective, the department shall enroll a family member who is not a Medicaid enrollee
7 into the HIPPP program if the family member has group health insurance plan coverage
8 through which the department can obtain health insurance coverage for a Medicaid-
9 enrollee in the family.

10 (2) The needs of a family member who is not a Medicaid enrollee shall not be taken
11 into consideration when determining cost effectiveness of a group health insurance
12 plan.

13 (3) The department shall:

14 (a) Pay a HIPPP program premium on behalf of a HIPPP program participating family
15 member who is not a Medicaid enrollee; and

16 (b) Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a
17 HIPPP program-participating family member who is not a Medicaid enrollee.

18 Section 7. Exceptions. The department shall not pay a premium:

19 (1) For a group health insurance plan if the plan is designed to provide coverage for a
20 period of time less than the standard one-year coverage period;

21 (2) For a group health insurance plan if the plan is a school plan offered on the basis
22 of attendance or enrollment at the school;

23 (3) If the premium is used to meet a spend-down obligation when all persons in the

1 household are eligible or potentially eligible only under the spend-down program
2 pursuant to 907 KAR 1:640.

3 (a) If any household member is eligible for full Medicaid benefits, the premium shall
4 be paid if it is determined to be cost effective when considering only the household
5 members receiving full Medicaid coverage.

6 (b) In a case described in subparagraph 1 of this paragraph, the premium shall not
7 be allowed as a deduction to meet the spend-down obligation for those
8 household members participating in the spend-down program;

9 (4) For a group health insurance plan if the plan is an indemnity policy which
10 supplements the policy holder's income or pays only a predetermined amount for
11 services covered under the policy; or

12 Section 8. Duplicate Policies. If more than one (1) group health insurance plan or
13 policy is available, the department shall pay only for the most cost-effective plan except
14 as allowed in subsection (2) of this section.

15 (2) In a circumstance where the department is buying in to the cost of Medicare
16 Part A or Part B for an eligible Medicare beneficiary, the cost of premiums for a
17 Medicare supplemental insurance policy may also be paid if the department determines
18 that it is likely to be cost effective to do so.

19 Section 9. Discontinuance of Premium Payments. (1) If all Medicaid-enrollee
20 household members covered under a group health insurance plan lose Medicaid
21 eligibility, the department shall discontinue HIPP program payments as of the month of
22 Medicaid ineligibility.

23 (2) If one (1) or more, but not all, of a household's Medicaid-enrollee members

1 covered under a group health insurance plan lose Medicaid eligibility, the dep-
2 artment shall re-determine cost effectiveness of the group health insurance
3 plan in accordance with Section 5(2).

4 Section 10. Health Insurance Premium Payment Program Payment Effective Date.

5 (1)(a) If health insurance premium payment program payments for cost-effective
6 group health insurance plans shall begin with the month the health insurance
7 premium payment program application is received by the department, or the effective
8 date of Medicaid eligibility, whichever is later.

9 (b) If an individual is not currently enrolled in a cost effective group health insurance
10 plan, premium payments shall begin in the month in which the first premium payment is
11 due after enrollment occurs.

12 (2) The department shall not make a payment for a premium which is used as an
13 income deduction when determining individual eligibility for Medicaid.

14 Section 11. Premium Refunds. The department shall be entitled to any premium
15 refund due to:

16 (1) Overpayment of a premium; or

17 (2) Payment for an inactive policy for any time period for which the department
18 paid the premium.

19 Section 12. Notice. The department shall inform a health insurance premium
20 payment program:

21 (1) Applicant, in writing, of the department's initial decision regarding cost
22 effectiveness of a group health insurance plan and health insurance premium payment
23 program payment; or

1 (2) Participating household, in writing:

2 (a) If health insurance premium payment program payments are being discontinued
3 due to Medicaid eligibility being lost by all individuals covered under the group
4 health insurance plan;

5 (b) If the group health insurance plan is no longer available to the family; or

6 (c) Of a decision to discontinue health insurance premium payment program
7 payment due to the department's determination that the policy is no longer cost
8 effective.

9 Section 14. Federal Financial Participation. (1) The department's health insurance
10 premium program shall be contingent upon the receipt of federal financial participation
11 for the program.

12 (2) If federal financial participation is not provided to the department for the
13 department's health insurance premium program, the program shall cease to exist.

14 (3) If the Centers for Medicare and Medicaid Services (CMS) disapproves a
15 provision stated in an amendment to the state plan, which is also stated in this
16 administrative regulation, the provision shall be null and void.

17 Section 15. Material Incorporated by Reference. (1) The "Application for Health
18 Insurance Premium Payment (HIPPP) Program, Form PA 41", September 2009
19 edition is incorporated by reference into this administrative regulation.

20 (2) The material referenced in subsection (1) of this section is available at:

21 (a) <http://www.chfs.ky.gov/dms/incorporated.htm>; or

22 (b) The Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky
23 40621, Monday through Friday, 8 a.m. to 4:30 p.m.

907 KAR 5:005

REVIEWED:

Date

Elizabeth A. Johnson, Commissioner
Department for Medicaid Services

APPROVED:

Date

Janie Miller, Secretary
Cabinet for Health and Family Services

907 KAR 5:005

A public hearing on this administrative regulation shall, if requested, be held on August 23, 2010 at 9:00 a.m. in the Cabinet for Health and Family Services, Health Services Building, Third Floor, Meeting Room B, 275 East Main Street; Frankfort, Kentucky; 40621. Individuals interested in attending this hearing shall notify this agency in writing by August 16, 2010, five (5) workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. The hearing is open to the public. Any person who attends will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to attend the public hearing, you may submit written comments on the proposed administrative regulation. You may submit written comments regarding this proposed administrative regulation until close of business August 31, 2010. Send written notification of intent to attend the public hearing or written comments on the proposed administrative regulation to:

CONTACT PERSON: Jill Brown, Office of Legal Services, 275 East Main Street 5W-B, Frankfort, KY 40601, (502) 564-7905, Fax: (502) 564-7573.

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 5:005

Cabinet for Health and Family Services

Department for Medicaid Services

Agency Contact Person: Teresa Shields (502) 564-4958 or Angie Lawrence (502) 564 5472

- (1) Provide a brief summary of:
 - (a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' (DMS's) health insurance premium payment (HIPPP) program provisions. The HIPPP program is a program by which DMS purchases health insurance coverage for an individual by paying the individual's (and family members if applicable) health insurance premiums, deductibles and coinsurance if doing so would be cost effective to DMS. To qualify for the HIPPP program, an individual (or at least one individual in the case of a family enrolling in the HIPPP program) must be Medicaid eligible; however, the actual benefits are provided by the individual's group health insurance carrier.
 - (b) The necessity of this administrative regulation: This administrative regulation is necessary to provide cost-effective medical benefits to Medicaid individuals; thus, prudently utilizing DMS's resources.
 - (c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by providing cost-effective medical benefits to Medicaid individuals.
 - (d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation assists in the effective administration of the statutes by providing cost-effective medical benefits to Medicaid individuals.

- (2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
 - (a) How the amendment will change this existing administrative regulation: This is a new administrative regulation.
 - (b) The necessity of the amendment to this administrative regulation: This is a new administrative regulation.
 - (c) How the amendment conforms to the content of the authorizing statutes: This is a new administrative regulation.
 - (d) How the amendment will assist in the effective administration of the statutes: This is a new administrative regulation.

- (3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Affected individuals include approximately 1,000 Medicaid individuals and family members that DMS

projects could be enrolled into HIPP by calendar year 2013.

- (4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:
- (a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment: Potential HIPP program enrollees will need to provide all required information, including their health insurance carrier's information, to DMS.
 - (b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). No cost is imposed on the regulated entities.
 - (c) As a result of compliance, what benefits will accrue to the entities identified in question (3). Medicaid recipients would have access to private health insurance with no out-of-pocket costs and non-Medicaid recipients (who are in a household that is participating in the HIPP program) could receive health insurance coverage if determined to be cost effective by DMS.
- (5) Provide an estimate of how much it will cost to implement this administrative regulation:
- (a) Initially: The Department for Medicaid Services (DMS) anticipates that 100 could be enrolled into HIPP in calendar year 2010, resulting in a savings to DMS of approximately \$2.0 million (\$1,593,400 federal/\$406,600 state)
 - (b) On a continuing basis: DMS projects the following HIPP enrollment and corresponding savings for calendar years 2011, 2012 and 2013 respectively:
 - 1. 2011: 500 cases with a savings of \$10.0 million (\$7,967,000 federal/\$2,033,000 state)
 - 2. 2012: 750 cases with a savings of \$15.0 million (\$11,950,500 federal/\$3,049,500)
 - 3. 2013: 1,000 cases with a savings of \$20.0 million \$15,934,000 federal/\$4,066,000 state)
- The projected savings assume that all individuals selected for HIPP program participating will participate; thus, actual savings could possibly be less. DMS intends to aggressively educate potential HIPP program participants regarding the benefits of the HIPP program in order to achieve a high participation rate.
- (6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under the Social Security Act, Title XIX and matching funds from state general fund appropriations.
- (7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding are necessary.

- (8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.
- (9) Tiering: Is tiering applied? (Explain why tiering was or was not used)
Tiering is applied as children are exempt from Medicaid disenrollment pursuant to 42 USC 1396e(b)(2).

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

Regulation Number: 907 KAR 5:005

Agency Contact Person: Teresa Shields (502) 564-4958 or Angie Lawrence (502) 564 5472

1. Does this administrative regulation relate to any program, service, or requirements of a state or local government (including cities, counties, fire departments or school districts)?

Yes X No _____
If yes, complete 2-4.

2. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by this administrative regulation.
3. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. KRS 205.520(3), 205.560(1), 194A.030(2), 194A.050(1), 194A.010(1) and 42 USC 1396e(a) through (e).
4. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.
 - (a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? DMS projects no revenue to be generated by the administrative regulation.
 - (b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? DMS projects no revenue to be generated by the administrative regulation.
 - (c) How much will it cost to administer this program for the first year? DMS anticipates that 100 could be enrolled into HIPP in calendar year 2010, resulting in a net savings to DMS of approximately \$2.0 million (\$1,593,400 federal/\$406,600 state.)
 - (d) How much will it cost to administer this program for subsequent years? DMS projects the following HIPP enrollment and corresponding savings for calendar years 2011, 2012 and 2013 respectively:

1. 2011: 500 cases with a savings of \$10.0 million (\$7,967,000 federal/\$2,033,000 state)
2. 2012: 750 cases with a savings of \$15.0 million (\$11,950,500 federal/\$3,049,500)
3. 2013: 1,000 cases with a savings of \$20.0 million (\$15,934,000 federal/\$4,066,000 state.)

The projected savings assume that all individuals selected for HIPP program participating will participate; thus, actual savings could possibly be less. DMS intends to aggressively educate potential HIPP program participants regarding the benefits of the HIPP program in order to achieve a high participation rate.

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

907 KAR 5:005

Summary of Material Incorporated by Reference

The Application for Health Insurance Premium Payment (HIPP) Program, Form PA 41, September 2009 edition, is incorporated by reference. The form is used to apply for health insurance premium program. The form contains one (1) page.