

Overview of the Iowa Health Insurance Premium Payment (HIPP) Program

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Since 1991, the state of Iowa has operated its Health Insurance Premium Payment (HIPP) program. HIPP pays premiums, deductibles and coinsurance, when cost-effective, for any Medicaid recipients who have access to employer-based or private plans. By taking advantage of available employer contributions, the state is able to lower the overall cost of operating the Medicaid program. This year the HIPP program is budgeted to save the state of Iowa \$3 million in Medicaid costs.¹ In addition to accessing coverage through their employer's health plan, HIPP participants are issued a regular Medicaid card and use Medicaid services to obtain coverage for any benefits that may not be covered by their employer's plan.

The Iowa program is unique because:

- it evaluates all Medicaid applicants for participation not only those applicants who have high-cost chronic illnesses. And,
- these premium payments are usually paid directly to the program participants.

In addition, if it is necessary to purchase a family plan, family members who are not Medicaid eligible may also obtain coverage. This uniformity of coverage makes it easier for families to navigate and use the health care system together. Finally, HIPP participants will have private health insurance available to them if Medicaid eligibility should be lost.

This paper describes not only how HIPP enrollees are identified but also how the state obtains and verifies information on their employer-sponsored coverage or non-group plan. In addition, it discusses how the state determines whether to purchase into an employer's or private plan. Finally, it will describe how participants obtain coverage at a provider's office as well as how premiums are paid.

Current Statistics

As of November 1999, approximately 8,441 people were participating in HIPP. Approximately, 5,574 participants are Medicaid-eligible. This represents three percent of the total Medicaid population in Iowa. The remaining HIPP participants, 2,867 people, are not Medicaid eligible but are covered as members of the family. It is estimated that the HIPP participants represent 2,300 Medicaid cases.

The HIPP office, a separate unit of the state Medicaid agency, operates independently of local eligibility offices. It employs 17 staff members, including 5 intake workers, 7 case managers, a secretary, and a policy specialist/lead worker. In addition, 3 computer specialists are working on systems development.

¹ Conversation with HIPP staff. 11/18/99

What is HIPP?

The HIPP program was originally developed to comply with Section 1906 of the Social Security Act. The Act requires states to pay premiums, deductibles, and coinsurance of employer-sponsored plans on behalf of Medicaid recipients when it is cost-effective to do so. Through the HIPP program, the state of Iowa pays the employee's share of the premium cost for Medicaid-eligible family members either to employees, their employers or, in some cases, insurance carriers. If it is necessary to purchase family coverage, non-Medicaid eligible family members may also obtain coverage under HIPP as a by-product of covering the eligible members. If employment is terminated, HIPP will also pay for COBRA coverage if it is cost-effective.

In addition, in some cases HIPP pays for the premiums, deductibles and coinsurance of cost-effective non-group plans. For instance, in one HIPP case, a self-employed farmer with several children, including one child who required extensive medical care, had been purchasing non-group coverage. The HIPP office concluded that it was cost-effective for the state to continue purchasing the non-group coverage because of the family size and the unusually large expense of the chronically ill child. However, since most often HIPP purchases coverage through an employer-sponsored plan much of the following discussion focuses on the employer aspect of the program.

Exclusions

Certain types of plans are not eligible for participation in the HIPP program. Premiums will not be paid when:²

- The policyholder does not live in the household with the Medicaid-eligible person.
- The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g. \$50 per day for hospital services instead of 80% of the charge).
- The insurance plan is a school based plan offered on the basis of attendance or enrollment at the school.
- The premium is used to meet a spend-down obligation under the Medically Needy program when all persons in the household are eligible or potentially eligible only under the Medically Needy program. (Note: A person may qualify for the HIPP program when some of the persons in the household are eligible for full Medicaid benefits even if others in the household must meet a spend-down obligation under the Medically Needy program.)
- The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30-180 days).
- The insured person is eligible only for limited Medicaid services under the Specified Low-Income Medicare Beneficiary (SLMB) coverage group.
- The insurance plan is through the Iowa Comprehensive Health Insurance Association (Iowa's high risk pool).
- The insurance plan is a Medicare supplemental policy. This applies to all applications filed on or after March 1, 1996.

Upon Application

When a person applies for Medicaid, the application that he/she must complete includes questions about whether or not the applicant is currently covered by or has coverage available through an employer-sponsored or non-group plan. If Medicaid eligibility is confirmed and the applicant has indicated that

² HIPP brochure

OVERVIEW OF THE IOWA HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

private coverage is available, the Medicaid eligibility worker automatically forwards the application to the HIPP program office. It is the HIPP program staff who gather information about the available employer or non-group coverage and determine whether or not purchasing that coverage would be cost-effective for the state. However, all state Medicaid eligibility workers are educated about the HIPP program and are responsible for ensuring that potential HIPP participants are referred to the program office. Since Medicaid eligibility is determined prior to acceptance into the HIPP program, the Medicaid recipient is enrolled in traditional Medicaid and uses traditional Medicaid services, if necessary, while waiting to be enrolled into the HIPP program.

Generally, the state does not extensively market the HIPP program to either employers or potential enrollees but HIPP staff have given presentations to community groups in order to publicize the HIPP program. They have also contacted employers directly about the program, in one case to get an employer's assistance in publicizing the program among workers whose plant was closing. A HIPP brochure, which outlines the program's purpose, structure and rules, is included in the application packet that all potential Medicaid enrollees receive. If a Medicaid recipient wants the HIPP office to investigate coverage that is available through a non-group plan, he/she can also apply for the HIPP program using the application in the HIPP brochure.

Determining whether Medicaid recipients will participate in the HIPP program

When the HIPP office receives notice from the eligibility office (local Social Services office) that a Medicaid recipient has employer coverage available, the HIPP staff must determine whether the coverage is cost-effective for the state to purchase the coverage for the Medicaid-eligible persons in the family. A cost-effective plan is a plan where paying for the employee's portion of the employer-based insurance premium will save the state at least five dollars per month when compared to the average cost to the state to provide the same services (covered by the employer plan) under traditional Medicaid. For example, a single mother and her two children are eligible for Medicaid and have access to an employer plan. The state compares the cost of providing the services offered under the employer's plan under traditional Medicaid to the cost of paying the mother's share of the health insurance premium for family coverage under the employer's plan. If conditions for cost-effectiveness are met, Medicaid recipients are required to enroll in the employer's health plan and the HIPP program pays the cost of the premium.—Failure to enroll in the health plan can result in cancellation of Medicaid benefits of the policyholder.

Obtaining and Verifying Employer Information

In order to determine cost-effectiveness, the HIPP staff must first obtain information on the health insurance plan. Necessary information includes the specific services covered, the amount of the employee's contribution toward coverage and the amount of any deductibles or coinsurance for which the employee is responsible.

Since the HIPP program began operation, the state has compiled an extensive collection of employer benefit plans. These plans are summarized and stored in hard copy form in what HIPP staff describe as a benefits plan library. Often the applicant's employer information will already be on file and it will not be necessary to contact the employer for each HIPP application. The HIPP computer systems staff is in the process of converting the information in the library into an electronic format. The electronic format will simplify the procedure the HIPP intake worker must go through in order to find information about a particular employer's plan.

If an employer's benefit plan is not on file, the intake worker contacts the employer in writing and requests that the information be sent to the HIPP office. If necessary, the HIPP worker follows up the initial request with a phone call to the employer. HIPP staff note that, as the program has matured, and

OVERVIEW OF THE IOWA HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

employers have become more familiar with the program and its rules, employers are increasingly cooperative about providing the information that the staff needs.³ Some employers voluntarily notify the HIPP office when there is a change in coverage.

Determining Cost-Effectiveness

To determine cost-effectiveness, the HIPP staff uses an automated system. The system first calculates the state's cost under the private insurance plan (premium, deductible and an additional HIPP administrative fee⁴). The system then subtracts from this sum the average Medicaid cost for the services covered under the employer's insurance policy. The result represents either a savings or a loss for the state. A savings of at least five dollars per month is necessary for the system to recommend that the state buy into the employer's coverage.

Average Medicaid costs are calculated based the age, sex, federal reporting category, institutional status and Medicare status of the HIPP applicant(s)⁵. The automated system computes the average cost for a similarly categorized Medicaid recipient to receive the services covered under the private plan (adjusted for inflation and anticipated provider increases).

There are several instances when the formal cost-effectiveness determination is not performed. These are: if the employee's share of the premium costs \$50 or less per month for a one-person Medicaid eligible household or \$100 or less per month for a household with two or more Medicaid eligible persons; or the plan provides coverage to a Medicaid-eligible pregnant woman.⁶ If any of these scenarios is true, the HIPP worker automatically approves the application for participation in the HIPP program.

If the automated system indicates that buying the employer's coverage is not cost-effective, a Medical History Questionnaire is sent to the applicant. The Questionnaire is used to determine whether any of the potential HIPP participants who would be covered under the employer's plan have chronic health conditions that would result in an above average expenditure for care. If so, cost-effectiveness is manually determined and the added expense of the chronic condition is taken into consideration.

If employer coverage is still not cost-effective, the application to the HIPP program is denied and the applicant(s) continue to receive care through traditional Medicaid. If the automated system indicates that buying the employer's coverage is found to be cost-effective, the HIPP staff proceeds with the process of enrolling the individual(s) into the employer's plan. If more than one policy is available and both are determined to be cost-effective, the state will pay the premium for only one plan.

Enrolling in the Employer's Plan

The HIPP caseworker sends to the HIPP participant a letter of acceptance into the HIPP program. The letter instructs the HIPP participant to apply for coverage, under his/her employer's plan, for all of the Medicaid-eligible persons in his/her household who can be covered under the plan.⁷ (This sometimes requires the HIPP participant to enroll in health insurance that covers non-Medicaid eligible persons.) For the participants' information, the letter indicates the plan type, premium amount and frequency with which premium payments are made, based on the information provided by the employer.

³ Conversation with HIPP staff. November 18, 1999.

⁴ The administrative fee represents the additional cost to the state of administering the HIPP program.

⁵ For the purpose of determining cost-effectiveness, the state does not need to know the limitations that a particular benefit may have. Instead, the worker simply verifies that a particular benefit is offered under the employer's health insurance plan.

⁶ HIPP brochure

⁷ A Medicaid recipient who is deemed to have cost-effective employer-sponsored health insurance available must enroll and stay enrolled in his/her employer's plan, as long as it is determined to be cost-effective, in order to maintain Medicaid eligibility.

OVERVIEW OF THE IOWA HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

The participant is asked to submit a written statement from his/her employer verifying that he/she has applied for coverage under the employer's plan. An Employer Verification Form is also enclosed with the acceptance letter, and the HIPP participant is requested to have his/her employer complete and return the form to the HIPP office when he/she has been approved or enrolled in the plan. If a participant has any questions about the program or the enrollment process, a toll free number for the HIPP office is provided.

HIPP participants are determined to be eligible for the program for one year, at which time cost-effectiveness is redetermined. Participants must continue in the program as long as they are Medicaid eligible and participation is cost-effective. However, if during the year, there is a change in employment, insurance or Medicaid status, the HIPP participant or his/her employer (depending on who is receiving the premium payments) is responsible for reporting the change to the HIPP office. Cost-effectiveness is redetermined when changes are received.

Employer Verification Form

Once a HIPP participant is enrolled in or has been accepted for coverage into an employer's plan, the employer or the employer representative must complete the Employer Verification Form in order for premium payment to begin. The form asks for information about the type(s) (medical, dental, and vision) and effective date of coverage for the employee and his/her dependent(s). The employer is also asked whether he/she would prefer to be paid directly for the employee's share of the premium or to have the employee reimbursed for any payroll deductions made for the insurance. It has been the experience of the HIPP program that 90% or more of employers elect to have the employee reimbursed for the health insurance premium. The employers who do volunteer to be paid directly are most often smaller employers who can more easily make adjustments to their payroll system.⁸ Also, when the HIPP participant does not earn enough to cover the premium contribution amount, the employer will often arrange to be paid directly.

If the employer chooses to be paid directly for the employee's share of the premium, the employer is asked to provide: the amount of the employee's contribution, the date that the first premium is due, and the frequency of payment (weekly, biweekly, semi-monthly, or monthly). If the employer chooses to have the employee reimbursed for payroll deductions for insurance, the employer must provide: the date of the first payroll deduction, the day of the week that the employee is paid, the amount of the deduction, the frequency of the deductions (weekly, biweekly, semi-monthly, or monthly) and whether the payroll deductions are made on a pre-tax basis. Occasionally, there is a lag time between when the applicant is approved for participation in HIPP and when the HIPP staff obtain the information needed to make premium payments. The HIPP program will reimburse the participant for all deductions made from the date of acceptance into the HIPP program.

In some cases, enrollment into the employer's plan is delayed because the employee must wait for the healthplan's open enrollment period. The HIPP staff sets these applications aside until the open enrollment period comes around, at which time the participant is enrolled into the employer's plan. Program participants continue to use traditional Medicaid services while waiting to be enrolled.

Payment Process

Once enrollment in the employer's health plan has been verified, premium payments can be made. Payments are made through the State of Iowa's Department of Revenue. Payments are paid to either the

⁸ Conversation with HIPP Staff. 11/18/99

OVERVIEW OF THE IOWA HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

insurance carrier, which is rare, the employer or, most often, the employee. If a HIPP participant is receiving coverage through a non-group health insurance plan, payment of the insurance premium is always made directly to the insurance carrier unless the family verifies premiums are being made via automatic bank account withdrawal. In which case, the family will be reimbursed directly. The HIPP participant forwards premium notices to the HIPP office. Since private, non-group plans are often not cost-effective, this payment arrangement is not common in the HIPP program. Only 10% of the participants receive coverage through a non-group plan.

If a HIPP participant is receiving coverage through his/her employer's plan, either the employee or employer receive the premium payments. As mentioned above, when the employer or the employer representative completes the Employer Verification Form, he/she selects the method of payment. The employer is given the choice of either being paid directly for the employee's share of the insurance premium or having the employee reimbursed for his/her share of the cost of coverage. Checks are issued through the Iowa Department of Revenue and a mailing service mails the checks to the appropriate party.

Most employers, however, elect to have the employee reimbursed for the premium cost. Reimbursement checks to HIPP participants are issued on the same schedule as the deductions from the participant's paycheck. If a HIPP participant has premium deductions taken out of his/her paycheck on a weekly basis, then HIPP will reimburse the participant on a weekly basis. This is true regardless of whether the participant is paid on a weekly, bi-weekly, monthly or semi-monthly basis. All reimbursement checks are issued by the mail service two to five days prior to the day the participant is issued his/her paycheck. This helps to ensure that HIPP participants do not have to wait for their reimbursement checks and are not inconvenienced as a result of participation in the HIPP program.

What happens in the Provider's office?

All HIPP program participants are issued both a private health insurance card, which they receive from either their employer's health plan or their individual, non-group policy and a traditional Medicaid card, which is annotated to show they have private coverage which should be billed first. When in need of care, the participant must visit a provider who is in their private plan's provider network and who has also contracted with Medicaid to provide services. The participant presents both insurance cards when making payment at the provider's office. Because the participant's Medicaid card indicates that he/she is a HIPP participant, the provider's office bills the private health plan first for the cost of care. Medicaid is billed for expenses beyond what is provided under the private plan, including any required deductibles and coinsurance.

The coordination of prescription drug benefits has proven too difficult for the HIPP program because Medicaid requires prior authorization for many drugs and the various agreements between private plans and pharmacies vary so widely. The participant instead receives traditional Medicaid prescription drug benefits. The Medicaid fiscal agent then follows up with individual insurance companies to recover the costs paid by Medicaid for prescription drugs.

Reporting Changes, Redetermination of Cost-Effectiveness and Disenrollment

HIPP participants and/or their employers are responsible for reporting, within ten days, changes that may affect eligibility for payment of premiums. Changes are reported using a change form which is mailed by the HIPP office with each premium payment. Possible changes include, but are not limited to: loss of employment, premium changes, benefit changes, change of address, change of carrier, loss of coverage, or birth. If the employer or the participant has any questions about what type of changes need to be reported, a toll free telephone number is provided on the form which can be used to contact HIPP

OVERVIEW OF THE IOWA HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

workers. The HIPP Unit is notified automatically by the Medicaid eligibility system when one or more members in the family become ineligible for Medicaid.

If a change occurs that may affect the participant's enrollment in the HIPP program, a cost-effectiveness test is performed, based on the new information, and appropriate adjustments are made. For instance, if premium payment amounts need to be adjusted, the HIPP staff makes changes within a reasonable time after being made aware of the necessity to do so. The longer the HIPP program has been in operation, the more familiar employers have become with it and its rules. Occasionally, because they are aware that some of their employees are obtaining coverage through HIPP, employers will voluntarily notify the program office when an insurance carrier changes, when premium rates change or when an employee is no longer participating in the healthplan.⁹

Each year, the HIPP staff routinely verifies the participant's health plan information and redetermines the cost-effectiveness of participation in the HIPP program. A letter is sent to the employer, through the HIPP participant, that details the information that the HIPP office has on record. The employer is asked to review and, if necessary, update the information listed. Information that is reviewed includes: names of persons covered under the policy, the amount of the employee's share of the premium, the frequency with which the premium payments are paid/deducted, the amount of the deductible, the name of the insurance carrier and the address where claims are submitted. The employer is also asked if any changes in the insurance plan are anticipated. (e.g. covered services) If a plan is reviewed and determined to be cost-effective, the participants continue to receive coverage through the HIPP program. If participation is no longer cost-effective but the participants are still Medicaid eligible, they revert to receiving coverage solely through the traditional Medicaid program.

If a change in coverage or eligibility occurs and the HIPP office is not notified, errors in premium payments may occur. The HIPP accounting system is structured to not only make but also receive payments. If an overpayment occurs, the HIPP staff is able to work with the participant to establish a repayment schedule. Overpayments that cannot be recovered in this way are referred to the normal state collection system. The HIPP staff reports that often they find out about changes in coverage because either an employer reports a change or a provider files a Medicaid claim after being denied by the employer plan. Medicaid eligibility workers also let the HIPP office know about changes in a participant's Medicaid eligibility status. Most often, premium payment errors occur because of the frequent job-hopping that is characteristic of the Medicaid population.¹⁰

The HIPP staff will also investigate whether or not COBRA coverage is cost-effective to purchase if a HIPP participant should become laid-off or unemployed. If the coverage is not cost-effective, the participant would revert to coverage solely through traditional Medicaid.

⁹ Conversation with HIPP staff. 11/18/99

¹⁰ Conversation with HIPP staff. 11/18/99