Title 20. Public Health and Welfare

Chapter XV. Division of Medical Services, Department of Human Services

Subchapter A. Generally

Part 575. Health Insurance Premium Payment (HIPP) Rules

Subpart 1. Generally

20 CAR § 575-101. Introduction.

(a) The Division of Medical Services may pay for health insurance premiums for Medicaid-eligible individuals if such payments are cost effective.

(b) This part contains the rules governing premium payments under the Arkansas Health Insurance Premium Payment (HIPP) program.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-102. Definitions.

As used in this part:

(1)(A) "Cost effectiveness" means 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.

(B) HIPP is not cost effective when:

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

(ii) The client's eligibility category is "aged";

(2) "Covered benefits" means:

(A) Medical assistance as defined in Section 1905 of the Social Security Act that is covered under the state Medicaid plan; and

(B) Any additional services covered under a waiver approved by the Secretary of the United States Department of Health and Human Services;

(3) “Equivalent services” means healthcare treatment and services that correspond with covered benefits;

(4)(A) “Family members” means family members whom the Division of Medical Services may choose to enroll into the health plan who are not Medicaid eligible, if cost effective.

(B)(i) For Medicaid-ineligible family members, the Division of Medical Services covers payment only for the premiums.

(ii) Other cost-sharing expenses are not covered.

(iii) The family member may reside in a different household;

(5)(A) “Group health plan” means any plan of an employer, or contributed to by an employer, including a self-insured plan, to provide health care, directly or otherwise, to the:

(i) Employer’s employees;

(ii) Former employees; or

(iii) Families of employees or former employees.

(B) A group health plan must meet Section 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to:

(i) Title XXII of the Public Health Services Act;

(ii) Section 4980B of the Internal Revenue Code of 1986; or

(iii) Title IV of the Employee Retirement Income Security Act of 1974;

(6)(A) “Health plan” means any health insurance plan that, in exchange for premiums paid, pays benefits for medical services.

(B) Medicare Part B premiums are excluded;

(7) “HIPP” means the Health Insurance Premium Payment program;

(8) “MMIS” means the Medicaid Management Information System; and

(9)(A) “Premium cost” means the premium cost which is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid.

(B) This accounts for Arkansas’s costs being based on per client data instead of per eligible data.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-103. HIPP program.

(a) The Division of Medical Services may cover payment of premiums for Medicaid beneficiaries enrolled in a cost-effective health plan.

(b) The division may also cover payment of deductibles, coinsurance, and other cost-sharing obligations under the health plan if the services are included in the state plan and provided to a Medicaid beneficiary.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-104. Medicaid eligibility unaffected.

(a)(1) Enrollment in a health plan does not change the client's eligibility for Medicaid benefits.

(2) 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.

(3) If the client's health plan offers more services than covered under Medicaid, the Division of Medical Services does not pay for the deductibles, coinsurance, and other cost-sharing obligations for those noncovered services.

(b) **Medicare enrollment.** If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, the division 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.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-105. 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.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-106. Enrollment.

(a)(1) Health plans usually limit an individual's enrollment period.

(2) If an individual who is already enrolled in a health plan becomes Medicaid eligible, the Division of Medical Services may cover premium payments as of the effective date of Medicaid eligibility.

(b) **Effective date of benefit.**

(1) If a client is not eligible for coverage under a health plan for a specified waiting period, the division may cover the premium as of the effective date of eligibility for the health plan.

(2) 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.**

(1) If the availability for enrollment in the health plan and eligibility for Medicaid do not coincide, the client/applicant shall apply for HIPP eligibility.

(2) The client/applicant will be enrolled in the health plan when eligible if still cost effective.

(d) **Annual renewal.**

(1) Cost effectiveness shall be reviewed at least annually.

(2) At least six (6) months of claims or EOBs will be reviewed during the renewal period.

(3) The annual renewal may coincide with the employer’s open enrollment period for employer sponsored plans.

Authority. Arkansas Code § 20-77-107.

Codification Notes. "EOB" means explanation of benefits.

20 CAR § 575-107. Cost effectiveness determination.

The Division of Medical Services determines the cost effectiveness of health plans using the following methodology:

(1)(A) The Medicaid client furnishes information on the health plan to the division.

(B) This information must include:

(i) The effective date of the policy;

(ii) Exclusions to enrollment;

(iii) The covered services under the policy;

(iv) Riders and exclusions of covered services; and

(v) Premiums paid by the policy owners;

(2) Using the Medicaid Management Information System (MMIS), the division obtains the total twelve-month estimated average inflation-adjusted Medicaid costs for persons comparable to the client with respect to:

(A) Age;

(B) Sex; and

(C) Category data; and

(3)(A) The division:

(i) Determines, if historical data is available, or estimates, if historical data is unavailable, the total twelve-month Medicaid expenditures for covered services (estimated average Medicaid cost);

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

(iii) Identifies the premium cost;

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

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

(vi) 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 twelve-month period.

(B)(i) The division determines the cost of HIPP by adding the amounts identified in subdivisions (a)(3)(A)(iii) – (vi) of this section and compares that cost to the estimated average Medicaid costs.

(ii) If the cost of the HIPP case is less than the estimated average Medicaid costs, the health plan is cost effective.

(iii) 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.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-108. Exceptional medical costs (special conditions).

If the client provides documentation of ongoing medical costs or future medical costs that exceed the estimated average Medicaid costs, the Division of Medical Services may determine that the health plan is cost effective.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-109. Balance billing.

(a) The Division of Medical Services pays only up to the Medicaid allowable amount.

(b)(1) For example, if a provider bills fifty dollars ($50.00) for a service and the insurer pays forty dollars ($40.00), but the Medicaid allowable is thirty-seven dollars ($37.00), Medicaid will not make up the ten-dollar difference between the billed amount and the insurance payment, nor can the provider bill the client for the difference.

(2)(A) If the provider bills fifty dollars ($50.00) and the insurance pays thirty-seven dollars ($37.00) and the Medicaid allowable is forty dollars ($40.00), Medicaid can pay the difference, up to the Medicaid allowable.

(B) In this case, Medicaid pays three dollars ($3.00).

(3) In both examples, the provider cannot bill the client for the difference between the Medicaid payment and the billed amount.

Authority. Arkansas Code § 20-77-107.

20 CAR § 575-110. Payment for services.

(a) The Division of Medical Services will pay the health insurance premium directly to the policyholder or designated party through premium payment from payroll deduction or individual plans.

(b) The division 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 20 CAR § 575-109.

Authority. Arkansas Code § 20-77-107.