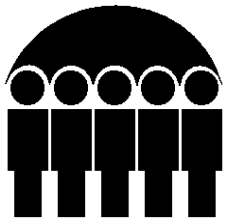
Employees' Manual
Title 5
Chapter B

November 19, 2004

HEALTH INSURANCE PREMIUM PAYMENT PROGRAM



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Department
of
Human Services

Page

Page

Page

OVERVIEW

Legal reference: 441 IAC 75.21(249A)

The purpose of the Health Insurance Premium Payment (HIPP) Program is to reduce Medicaid costs by obtaining or maintaining health insurance coverage for Medicaid-eligible persons when it is determined cost-effective to do so. The HIPP program uses Medicaid funds to pay for employer-group and, in some instances, individual health insurance coverage.

The Health Insurance Bureau of the Division of Financial, Health, and Work Supports in Central Office administers the program.

The policies and procedures governing the operation of the HIPP Unit are outlined in this chapter. Local office income maintenance (IM) worker responsibilities are covered in:

- 8-M, **HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP)**
- 8-C, **Cooperation With the HIPP Unit** and **Failure to Cooperate With the HIPP Program**

Definitions

Legal reference: 441 IAC 75.25(249A) and 75.21(3)

In this chapter:

- **"Cafeteria or flexible benefit"** plan means an employer-sponsored plan that uses either the employee's or employer's money to pay certain expenses, such as child care, medical expenses, health insurance, annual leave or sick leave.
- **"COBRA coverage"** means the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) that give certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continued coverage through an employer group health plan.

  The coverage continues at group rates upon the employee's termination of employment, reduction in the number of hours of employment, or other qualifying event that affects the employee's or their dependent's eligibility for health insurance.

  For legal requirements for COBRA coverage, refer to the publication, *Health Benefits Under the Consolidated Omnibus Budget Reconciliation Act COBRA,* published yearly by the U.S. Department of Labor, Employee Benefits Security Administration.

- **"Cost-effectiveness"** means the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premium and cost-sharing obligations under an insurance plan for those services.
- "**ERISA"** means the Employee Retirement Income Security Act of 1974, a federal law that sets minimum standards for most voluntarily established health and pension plans in private industry. Among its requirements, this law mandates plans to provide participants with plan information.
- **"Group health insurance"** means any policy made available by an employer to provide health care to employees, former employees, or the families of the employees or former employees. This includes self-insured **ERISA** employer plans.
- **"Health insurance"** means a contract that provides payment for covered services needed for sickness or injury, or preventative health care.
- **"HIPP"** means the Health Insurance Premium Payment program.
- **"HIMM system"** means the primary system for the HIPP program. All screens for data entry of participant, premium data, policy, individual Medicaid eligibility, and coverage information are found here. Access this system from the main CICS menu.
- **"HIPS"** means the secondary system used to enter and store information regarding the health insurance plans of individual employers. A list of insurance company codes and addresses provided and updated by the fiscal agent is also accessible on this system.
- **"Individual health insurance"** means any health insurance policy that is not a "group health insurance" policy as defined above.
- **"Mandatory participant"** means a person who is eligible for coverage through a group health insurance plan that has been determined cost-effective.
- **"Overpayment"** means the dollar amount of HIPP payments received by or on behalf of a person or household in excess of what is allowed by law for any given period.
- **"Participant"** means one who participates in or seeks to participant in the HIPP program.
- **"Recovery"** means the repayment of an overpayment, whether it is made directly by the debtor or is recovered by payment reduction.
- **"Voluntary participant"** means a person who has health insurance from a source other than an employer.

Persons Eligible to Participate

Legal reference: 441 IAC 75.21(1), (2), and (4)

Three groups of people are eligible for the HIPP program when cost-effective insurance coverage is available:

- **Mandatory participants** are people who have health insurance available through an employer. Mandatory participants are automatically evaluated for participation in the HIPP program when the local IM worker makes a referral to the HIPP Unit.

  When the HIPP Unit determines that it is cost-effective to pay for available group health insurance, mandatory participants must enroll in or continue enrollment in the health insurance plan as a condition of Medicaid eligibility.

  Eligibility for HIPP participation extends to all Medicaid-eligible persons in the participant's household. This includes children placed outside the home for medical care or temporary absences from the home to pursue education, as long as the Child Support Recovery Unit (CSRU) does not consider the participant an "absent parent."

  Children placed in foster care may be covered by the policy for which the HIPP program pays, but are not included in the cost-effectiveness determination. These children are excluded from the cost-effectiveness determination in an effort to avoid conflict with the determination of parental liability, much the same as children covered by absent parent insurance are excluded from the cost-effectiveness determination.

  Disabled adult children who are covered by the participant's insurance and are living outside the home are included in the cost-effectiveness determination. As adults, there would be no child support obligation to consider for these individuals.

- **Voluntary participants** are people who receive health insurance from a source other than an employer, such as a credit union, church affiliation, or private organization, or from an individual policy.

  These people can participate in the HIPP program if they apply and the HIPP Unit determines that the health insurance is cost-effective. Voluntary participants are not required to enroll in or continue with the health insurance as a condition of Medicaid eligibility.

- **Non-Medicaid-eligible participants** are family members who are not eligible for Medicaid but who are also enrolled in the health insurance plan that has been determined cost-effective. Only the Medicaid-eligible family members are considered in determining the cost-effectiveness of the plan.

> Mrs. P, her spouse, and their two children are enrolled in the family plan of her employer-sponsored health insurance. The two children are the only Medicaid-eligible members in the household. The plan is determined cost-effective when considering only the children. Mr. and Mrs. P are considered non-Medicaid-eligible HIPP participants, since they are also covered by the plan.

Health Plans Eligible for Payment

Legal reference: 441 IAC 75.21(1), (2), and (11)

Not all types of insurance plans are eligible for payment under the HIPP program. The health plans that can be evaluated for cost-effectiveness are typically those that provide major medical and other comprehensive medical coverage. These plans generally fall into three categories.

- Employer group plans (See the definition of **group health insurance**.)
- Individual plans (See the definition of **individual health insurance**.)
- COBRA (See the definition of **COBRA coverage**.)

Plans Not Eligible for Payment

Legal reference: 441 IAC 75.21(5)

Insurance plans that are not designed to provide major medical and other comprehensive medical coverage as the primary payer are not eligible to be considered for payment by the HIPP program. These plans are generally designed to provide coverage only under certain circumstances or only for limited periods, or are designed to supplement another type of policy or the participant's income.

Additionally, because of medical support enforcement policies required by the Child Support Recovery Unit, HIPP payment cannot be made when the participant is an absent parent. HIPP payment cannot be made for a plan when:

- The participant of the health insurance plan is an absent parent.
- The plan is an indemnity policy that supplements the participant's income or pays only a predetermined amount for services covered under the policy.
- The plan is a school plan offered based on attendance or enrollment at the school.
- The plan is designed to provide coverage for only a temporary period (e.g., 180 days).
- The plan is a Medicare supplemental policy and form 470-2875, *Health Insurance Premium Payment Application*, was received on or after March 1, 1996.
- Insurance is being provided through the Iowa Comprehensive Health Insurance Association.
- The plan is an "accident" plan that provides coverage only for medical expenses that result from an accident.

Payment of Claims

Legal reference: 441 IAC 75.21(10)

The fact that the Department is paying premiums to provide health insurance (as a "third-party resource") shall not affect Medicaid eligibility, except to the extent that the health insurance premium shall not be allowed as a deduction to income when the Department pays it.

Medical claims for persons participating in the HIPP program shall be paid in the same manner as claims for other Medicaid-eligible persons with a third-party resource.

Rate Refunds

Legal reference: 441 IAC 75.21(14)

Occasionally, insurance carriers make refunds to the participant when claims against the carrier are lower than expected. If the participant receives a rate refund, the participant must pay the Department any portion of the refund intended for any period for which the Department paid the premium.

When you receive these funds in the HIPP Unit, forward them to the fiscal agent to be applied to the payment of claims.

Narration

Case record documentation (narration) is crucial for correct cases. Quality Control errors and auditing reports of errors can be minimized by good documentation. Thorough and accurate documentation allows anyone to follow the activity on a case and justifies the actions that have been taken.

As a rule, good case narration includes:

- Progress notes in the front of each case record. These notes should be a complete history of every action taken on the case, including telephone calls, explanations, or other clarifying information.
- Dates on each entry made on the progress notes.
- Any information that makes the case more understandable.
- Documentation of a collateral contacts (employer, insurance company, etc.) as follows:
  - Record the date of the contact.
  - Record the name of the person who provides the information and the person's telephone number or other contact information.
  - Record the information provided.
  - Record the action taken because of the information obtained.
  - Initial the entry.

APPLICATION PROCESS

Legal reference: 441 IAC 75.21(249A)

Medicaid-eligible persons who have health insurance available through an employer are automatically evaluated for participation in the HIPP program when a referral is received from the local IM worker or the availability of group health insurance otherwise becomes known to the HIPP Unit.

Local office IM workers are required to make referrals to the HIPP Unit for all employed households that include Medicaid-eligible individuals. Referrals are made at the time an application is approved or when a member on an existing case becomes employed.

Additionally, the local IM worker makes a referral and cost-effectiveness is determined when a member of a Medicaid-eligible household loses employment, in order to establish whether insurance can be continued under the provisions of COBRA.

Medicaid-eligible persons who have health insurance available through a source other than an employer must file an application for participation in the program.

Three types of applications are accepted when determining eligibility for the HIPP program:

- Electronic referrals: A referral by the local IM worker using the HIRF referral process from the TD03 screen of the ABC system. When the referral is entered into the HIMM system, it becomes the "application" for the HIPP program.
- Paper referrals: A referral by the local IM worker made by sending or faxing the *Employer's Statement of Earnings*, form 470-2844, to the HIPP Unit.
- Direct applications: An application filed by the participant using form 470-2875, *Health Insurance Premium Payment Application*, which is found in the HIPP brochure (Comm. 91). Generally, this form is used to apply for the HIPP program for individual plans. However, a direct application may also be accepted if the participant of a group health plan independently applies.

The intake process consists of several components, including logging the application into the HIMM system, identifying the household members who are potentially eligible to participate in the program, gathering the information about the health plan, determining cost-effectiveness of the coverage, and enrolling eligible applicants in the plan.

Logging Applications

An electronic referral made through the HIRF process generates the report *HIPP Policyholder Referral Information* to the HIPP Unit. Logging is automated for these applications. Upon receipt, **support staff** shall:

- Review the *HIPP App/Case Found for Referrals Loaded to App Log* (report C474H312-1) to identify any possible duplicate applications previously entered on the application log, as well as any active HIPP cases associated with the participant. (See **REPORTS** for additional information on the H312-1 report.)

  Forward referrals that show a possible match with an active HIPP case to the IM worker responsible for the case.

- Refer all HIRF applications to the appropriate IM worker as soon as possible and no later than then end of the day in which the printed copies are received in the HIPP Unit.

Upon the receipt of a paper referral or direct application, **support staff** shall:

- Date-stamp the application. This date establishes the base period for retroactive payments and the processing time for the application. See **Time Limit for Establishing Eligibility** for more information.

- Log the application on the Application Log Detail Information (HILDMAP) screen. Enter any future enrollment date onto the application log in the area marked: FUTURE ENROLLMENT DATE and refer this application directly to the clerk specialist, who will hold it until it can be processed. See **Future Enrollments** for additional information.

- Manually search for duplicates when entering applications onto the application log. Forward referrals that show a possible match with an active HIPP case to the IM worker responsible for the case for investigation and resolution.

- Print the TD07 and TD01 screens for the case. Attach the screen prints to the paper referral or applications.

- Refer all paper referrals and direct applications to the IM worker as soon as possible and no later than three working days of receipt in the HIPP Unit.

Initial Application Review

Upon receipt of an application, the **IM worker** shall:

- Review the application or referral and any attached ABC screen prints to:
  - Identify all Medicaid-eligible persons in the household who may be covered by or are eligible for coverage under the health plan; and
  - Determine if other insurance is currently coded on the ABC system.
- If other insurance coding is present, check the MMIS screen to determine the source of the coverage (e.g. absent parent coverage, terminated coverage, etc.).
  - If the coverage showing on the MMIS screen has been entered within the previous 12 months, consider it current and take appropriate action, identifying the source of the coverage and excluding those individuals covered by the policy from the cost-effectiveness determination.
  - If all individuals are covered by other insurance, refer the application to the intake clerk for denial.
  - If the information is older than 12 months, contact the fiscal agent to verify the coverage.
  - If the coded insurance appears to be coverage provided by an absent parent (regardless of how old the information is), contact the fiscal agent to verify if the coverage is current.

    If the coverage is current, instruct the intake clerk to exclude any children covered by absent parent insurance from the cost-effectiveness determination.
- In all cases where other insurance is identified on the MMIS screens, copy the screens and attach them to the application.
- Then forward the application to the intake clerk for processing. Forward the application to the intake clerk as soon as possible but not later than five working days after receiving it from support staff.

- Provide the intake clerk with instructions on how each application should be handled. To provide appropriate instructions to the intake clerk:

  - Identify what Medicaid-eligible persons to include in the cost-effectiveness determination by circling their names on the *HIPP Policyholder Referral Information* or on the TD07 screen print.

    When there is no cost for the coverage of the participant, the participant is not included in the cost-effectiveness determination. (The intake clerk will be able to determine this from the employer information.)

    Children who are covered by absent parent insurance or who are out of the home in a foster care placement are not included in the cost-effectiveness determination.

  - Identify the presence of a pregnant woman in the household and the pregnancy due date.

  - Instruct the intake clerk to deny HIPP eligibility if the application notes that the employer does not offer health insurance to employees.

  - Instruct the clerk to deny for no Medicaid eligibility if the *HIPP Policyholder Referral Information* or the TD07 screen print indicates that there are currently no Medicaid-eligible persons in the household and haven't been for 30 days.

  - Instruct the intake clerk to hold the application for 30 days, or until a Medicaid eligibility decision is reached, if Medicaid eligibility is pending.

  - Instruct the intake clerk to recheck Medicaid eligibility at the beginning of the following month for those applications currently showing no Medicaid eligibility or Medicaid eligibility pending cancellation at the end of the current month.

    At the end of 30 days, if current Medicaid eligibility is found, the intake clerk shall proceed with processing the application.

    If there is no Medicaid eligibility at this point, the intake clerk shall refer the application to the IM worker for direction on whether to continue to hold for Medicaid eligibility or to deny the application due to lack of Medicaid eligibility.

Verifying Availability, Cost, and Covered Services

After receiving the application and instructions from the IM worker, the **intake clerk** does the initial fact gathering on each application in order to determine the cost-effectiveness of the plan. See **ESTABLISHING COST-EFFECTIVENESS** for additional information.

The procedure varies, depending on the type of health plan for which cost-effectiveness is being determined. Document the Application Log Detail Information (HILDMAP) screen, throughout the intake process as necessary to track the progress of the application.

Group Health Plans

When establishing cost-effectiveness for group health plans, the intake clerk shall:

- Review the information to determine if there are any restrictions on when the employee can enroll in the plan.

  When the employer restricts enrollment to a future open enrollment period, update the Application Log Detail Information (HILDMAP) screen to include a future enrollment date.

  One month before that date, the system generates a *HIPP Future Enrollment Report* (S474286-A) to the intake clerk. Evaluate HIPP eligibility as described below. It is imperative that HIPP eligibility be evaluated just before the open enrollment date, so that the applicant does not miss the window for enrollment. See **Future Enrollments** for more information.

> Ms. A applies for Medicaid for herself and her three children on September 12. Ms. A is employed part time. The *Employer's Statement of Earnings* verifies that group health insurance is available to Ms. A and her dependents.
>
> Since Ms. A did not enroll in the plan when she became employed, the employer requires her to wait until the next open enrollment period in January before she can enroll in the plan.
>
> In December, the intake clerk reviews Medicaid eligibility and determines the cost effectiveness of the insurance coverage. If the plan is determined to be cost-effective, Ms. A must enroll in the plan during the open enrollment period as a condition of her Medicaid eligibility.

- Check the employer file in the HIPP Employer Library (HIPS-HIPP Employer Sub-Menu), if it is determined that the participant can enroll in the plan, to determine if current information (updated within the previous 12 months) about the employer's health insurance plan is on file. See **Creating and Updating the HIPP Employer Library** for more information.

  - **Current information on file**. If the file information is consistent with information that was provided with the application, evaluate the cost effectiveness of the plan.

  - **No current information on file**. If current information on the employer's health plan is not on file or the information on the file is inconsistent with the information received with the application, send a request for information to the participant.

    Request any information needed to determine the cost effectiveness of the plan. Request the necessary information as soon as possible but no later than five working days after receiving the application from the IM worker.

    Notify the local IM worker of noncooperation if the requested information is not provided within ten working days and the participant has not requested more time to provide the information. The local IM worker will determine whether a sanction is appropriate. See **COOPERATION** for more information.

- Evaluate the plan for cost-effectiveness upon receipt of the requested information. See **ESTABLISHING COST-EFFECTIVENESS** for procedures.

  If the plan is determined not cost-effective, issue form 470-2847, *Denial of Health Insurance Premium Payment*, and update the Application Log Detail Information (HILDMAP) screen to reflect the action taken.

- Send the participant a letter within three working days of determining that the plan is cost-effective, requesting that the participant provide proof of enrollment within ten working days. See **COOPERATION** for more information. Follow these procedures:

  - **Currently enrolled**. If the Medicaid-eligible family members are currently enrolled in the plan option for which the HIPP program will pay, send form 470-3036, *Employer's Verification of Insurance Coverage*, with the letter to be completed and returned by the employer.

It may be necessary to ask the employer to return the form to the participant to return to the HIPP Unit. This is acceptable as long as the form is completed and signed by the employer. Ultimately, it is the participant's responsibility to return the form to the HIPP Unit.

- **Not enrolled**. If the Medicaid-eligible family members are not currently enrolled in a plan that has been determined cost-effective, send a letter requesting that they enroll in the appropriate available option (i.e. employee + 1, employee/children, or family option).

  Send form 470-3036, *Employer's Verification of Insurance Coverage*, with the letter to be completed by the employer.

♦ Review the verification of enrollment information for completeness and resolve any discrepancies in the information with the employer before forwarding the information to the IM worker.

♦ Forward the application and all accompanying documentation and verification to the local IM worker, who will approve the ongoing case and initiate premium payment. Forward the information to the IM worker as soon as possible but no later than three working days after receiving it.

COBRA Plans

When employment ends, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the intake worker shall:

♦ Verify whether insurance may be continued under the provisions of:

- The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985,
- The Family Leave Act, or
- Some other continuation provisions.

Use form 470-3037, *Employer Verification of COBRA Eligibility*, to obtain this information. Depending on the circumstances, send the form to the employee (or former employee) or to the affected dependent who may qualify for COBRA. This form must be completed and signed by the employer.

- Determine whether payment for COBRA coverage is cost-effective after the needed information is received.

  If the determination is that payment for COBRA coverage is not cost-effective, issue form 470-2847, *Denial of Health Insurance Premium Payment,* informing the applicant that COBRA premiums will not be paid.

- Notify the employee (or former employee) within three working days of determining cost-effectiveness to enroll in the COBRA coverage for the Medicaid-eligible individuals and provide verification that this has been done.

- Refer the application to the IM worker to establish an ongoing case once verification of the COBRA enrollment is received.

Individual Health Plans

When establishing cost-effectiveness for individual health plans, the intake clerk shall:

- Send a request for information to the participant if the necessary plan information was not provided with the application. This letter requests a copy of the policy, including the declarations page showing who is covered by the policy, verification of the current premium, and proof of payment.

- Deny the application using form 470-2847, *Denial of Health Insurance Premium Payment,* if the requested information is not returned within 10 working days.

  Update the Application Log Detail Information (HILDMAP) screen to reflect the action taken. No sanction is applicable, since participation in the HIPP program is voluntary for people with individual health plans.

- Determine cost-effectiveness of the plan when the needed information is provided. See **ESTABLISHING COST-EFFECTIVENESS** for procedures.

  - If the plan is determined to be cost-effective, forward the application with all documentation and verification to the IM worker as soon as possible but no later than within three working days of making the determination.

  - If the plan is determined not cost-effective, deny the application using form 470-2847, *Denial of Health Insurance Premium Payment,* and update the Application Log Detail Information (HILDMAP) screen to reflect the action.

Creating and Updating the HIPP Employer Library

In the course of the initial intake process, the intake clerk receives specific information on the health insurance plans of individual employers. This information is kept on file in the HIPP Employer Library so that information about an employer's plan does not have to be requested each time an employee is referred to the HIPP program.

If the HIPS system already contains a file on the employer, it is the responsibility of the intake clerk to ensure that the information is kept as current as possible. When new information is received about an employer's health plan, the intake clerk updates the employer information both on the HIPS system and in the hard copy of the file.

If the insurance information is new to the HIPP employer library, the intake clerk creates a system entry on HIPS, entering all available health insurance information and creates an appropriate hard copy file for the employer to be included in the library.

Time Limit for Establishing Eligibility

Legal reference: 441 IAC 75.21(12)

Make a decision about the cost-effectiveness of the plan and notify the applicant of the decision as soon as possible and within 65 calendar days. This period begins with the date the HIPP Unit receives the electronic HIRF referral; the *Employer's Statement of Earnings*, form 470-2844; or the *Health Insurance Premium Payment Application*, form 470-2875.

In most cases, it will take less than 65 days to establish eligibility and to notify the applicant of the decision. Delays can occur when there are extenuating circumstances beyond the control of the applicant or the Department that prevent the HIPP eligibility determination from being made. Some examples include:

- Illness of the applicant or a member of his or her family.
- Disasters, such as fire, flood, or tornado.
- Restrictions on employee enrollment until a future open enrollment period.
- Non-cooperation of an employer or insurance carrier to provide information necessary to establish cost-effectiveness.

Future Enrollments

When an application indicates that health insurance is available but the employee must wait until an open enrollment period to enroll, the application is held for processing until that time. The application is processed as follows.

Intake clerks receive a *HIPP Future Enrollment Report* (S474286-A) at the beginning of each month that identifies the applications with an open enrollment period for the following month. For example, the April report indicates which participants are eligible for enrollment in May. On the third working day of the month, the clerks shall:

- Pull all applications on the list.
- Review Medicaid eligibility, attaching TD07 and TD01 screen prints to the application.
- Pass applications and screen prints to the IM worker for review.

The IM worker shall review the applications as if they were new applications. The IM worker will return the applications to the intake clerk as soon as possible, but no later than the 13th of the month (or the next working day), with directions for processing.

The intake clerk shall process the applications in the same manner as if they were new applications.

If it becomes known to anyone (support staff, intake clerk, or IM worker) after the initial logging of the application that insurance eligibility is subject to future enrollment, that person shall update the application log with the future enrollment date, to put that application into the tracking process for future enrollments.

Approval

Within five working days after receiving the application and necessary verification, the IM worker shall approve the ongoing case, initiate premium payment, and update the Application Log Detail Information (HILDMAP) screen to reflect the action taken.

To complete the approval process, the IM worker shall:

- Review form 470-3036, *Employer Verification of Health Insurance*, for accuracy and completeness.
- Resolve any discrepancies or return the application to the intake clerk for resolution.
- Complete the application checklist and follow all directions on the form.
- Make required entries on the HIMM system.
- Issue an approval notice from the HIANMAP screen of the HIMM system.
- Update the application log.
- Add the approval to the savings log.
- Complete the narrative form in the case record to show the action taken.
- Follow up with a letter requesting a pay stub from the participant (if applicable).

ESTABLISHING COST-EFFECTIVENESS

Legal reference: 441 IAC 75.21(3)

The cost-effectiveness of an available health insurance plan is determined by comparing the cost of buying the services that are covered under the plan to what Medicaid would pay for those same services for a person with the same demographic profile (age, sex, health status, medical aid-type, etc.).

If buying the health insurance plan is determined to be cheaper than paying for those services only with Medicaid, the plan is determined to be cost-effective. In certain circumstances, a health plan may automatically be determined cost effective. See **Deemed Cost-Effectiveness** for more information.

The intake clerk evaluates cost-effectiveness at the time of initial application. The IM worker evaluates cost-effectiveness at the annual review and when changes are reported on existing cases that may affect the continued cost-effectiveness of the plan.

When establishing cost-effectiveness, it is important to identify the Medicaid-eligible family members in the household and which of those members are covered or could be covered by the health plan.

Another factor that must be considered is the plan option in which the family is enrolled or could enroll. Employers may offer coverage to their employees only or offer coverage to the dependents of their employees also. Some employers offer coverage options, so that employees can tailor coverage to meet their specific household circumstances, such as employee + family, employee + children, employee + spouse, employee + one other person, etc.

Cost-effectiveness can generally be established using the computerized formula in the HIMM system. However, since the data used in the formula is based on average utilization of Medicaid services, it is necessary to establish that the Medicaid-eligible persons in the household do not have an illness or chronic health condition that would lead to higher-than-average utilization of medical care before denying participation in the HIPP program.

Refer to **The "Buy" or "Don't Buy" Recommendation** for more information.

Not Enrolled at Time of Application

If no Medicaid-eligible family members are enrolled in the health plan when the HIPP Unit receives the application, calculate cost-effectiveness using the needs of all Medicaid-eligible persons who are not covered by other insurance and the cost and benefits of the least costly available option necessary for the eligible persons to be covered.

If coverage is cost-effective, request that the employee enroll in this option. For example, if two children are Medicaid-eligible, request enrollment in the "employee + children" option, if available.

Usually, the employee must also be covered by the plan in order to cover dependents. Therefore, the cost of covering the employee must be included even though the employee may not be Medicaid-eligible. If the employee chooses to enroll in the "family" option, the employee will be responsible for paying the difference in the premium options.

For an individual plan, attempt to obtain verification of the premium cost for the Medicaid-eligible persons. If that information is not available from the insurance company, the cost of the plan for all covered individuals will be used in the cost-effectiveness determination.

Enrolled at Time of Application

If the participant is enrolled at the time of HIPP application, establish cost-effectiveness based on the least costly option that will not negatively affect the participant.

For example, if the participant is enrolled in the 'family' coverage option and an 'employee + children' option is available that would cover all Medicaid-eligible persons in the household, use the cost of the 'employee + children' option in the cost-effectiveness determination. If cost-effective, the HIPP program will only pay the cost of this option.

> Mr. M is enrolled in the family option of his employer's health plan. Mr. M's employer offers coverage options for employee only, employee + spouse, employee + children and family. Mr. M has two children who receive Medicaid benefits. No one else in the household receives Medicaid benefits.
>
> The HIPP worker determines cost-effectiveness based on the premium cost for the 'employee + children' option and the needs of the Medicaid-eligible children. If the plan is cost-effective, the HIPP program will pay the cost for the 'employee + children' option. Mr. M will not be negatively affected by this action, since he was already paying the higher cost of family coverage.

Do not request the participant to drop existing coverage on household members or incur additional cost to pay for another option that will cover the Medicaid-eligible individuals in the family.

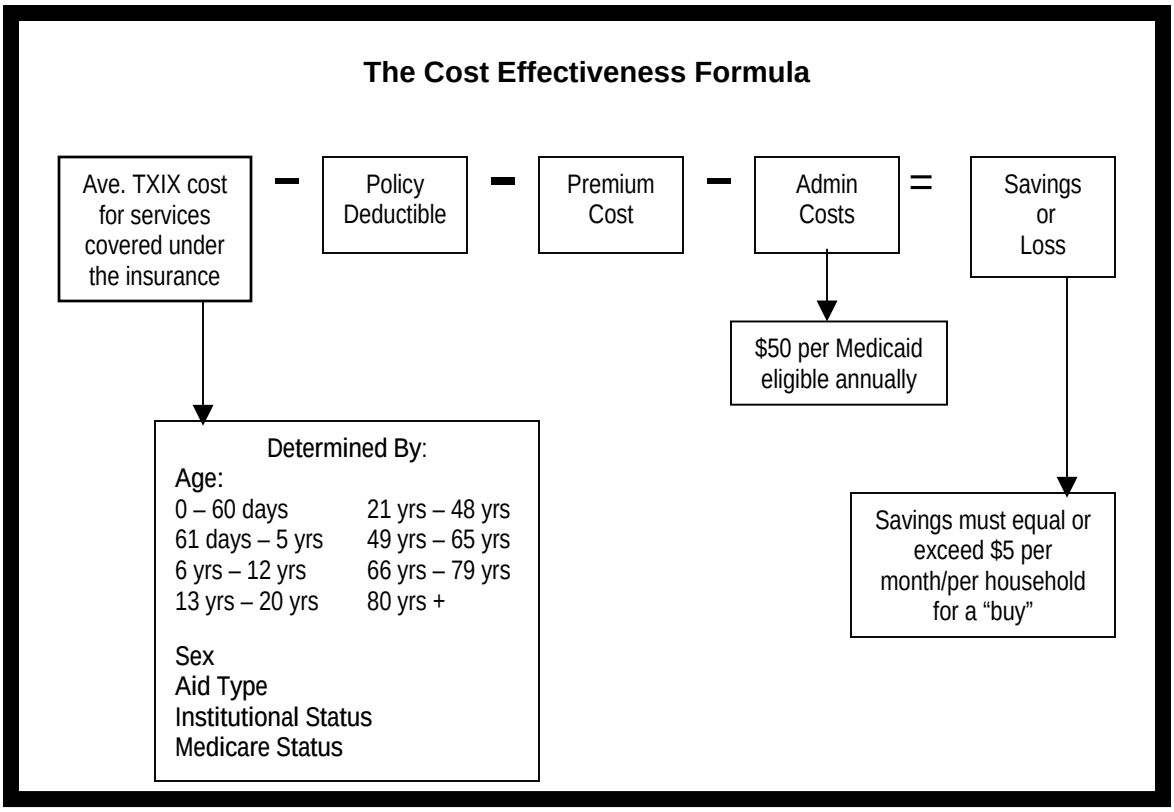
> Ms. Z works for the same employer as Mr. M in the previous example. Her two children receive Medicaid benefits, but she and her husband do not. Because her two children are covered by Medicaid, Ms. Z has chosen to enroll in the 'employee + spouse' option.
>
> The HIPP worker determines cost-effectiveness based on the cost of the 'family' option and the needs of the two Medicaid-eligible children. The worker cannot request enrollment in the 'employee + children' option, because this would require Ms. Z to drop the 'employee + spouse' coverage.
>
> If the plan is cost-effective, the HIPP worker will request Ms. Z to enroll in family coverage. Requiring enrollment in the family plan will have no negative impact on Ms. Z's coverage of the household members already covered by the plan. She will not be asked to incur extra expense to cover the Medicaid-eligible children.

The Cost-Effectiveness Formula

Legal reference: 441 IAC 75.21(3)

When determining cost-effectiveness of the health insurance plan, the automated system considers the following data:

- The cost of the premium and deductibles.
- The services covered under the insurance plan, including exclusions for pre-existing conditions, etc.
- The average anticipated Medicaid utilization for the services covered by the plan by age, sex, and coverage group for Medicaid-eligible persons who are covered or could be covered under the plan. (See **Unborn and Newborn Children** for policies regarding the age to use when calculating cost-effectiveness for newborn children.)
- Annual administrative expenditures of $50 per Medicaid-eligible person covered or who could be covered under the health plan.
- The estimated savings to Medicaid. If the savings is determined to be at least $5.00 per month per household, the plan will be cost-effective.



Based on the information entered regarding the Medicaid-eligible persons covered under the plan, the cost of the plan, and the services covered, the system makes a recommendation to "buy" or "not buy" the plan. Additionally, the system calculates an estimated savings if the plan is cost-effective or loss if the plan is not cost-effective.

Determining What Data to Enter for the System Calculation

Three categories of data must be entered into the HIMM system to determine cost-effectiveness:

- The Medicaid-eligible people who can be covered (added to the system by state ID number); and
- The cost of buying the coverage (includes the cost and frequency of premiums and applicable deductibles); and
- The benefits covered.

Consider the following when entering data into the HIMM system for the cost-effectiveness determination:

- Include only the Medicaid-eligible individuals who are or who could be covered by the plan for whom there is a cost to the participant (those that are not covered by an absent parent policy or other insurance).
- If coverage is free to the employee or other persons in the household, do not include those persons in the cost-effectiveness calculation, even if they are eligible for Medicaid.
- If the participant is Medicaid-eligible and there is a cost to them the participant for coverage, the first state ID number entered for cost-effectiveness determination should be the participant's.
- If the participant is not used in the calculation, enter the name of the participant in the "Remarks" field of the first person entered in the calculation.

When entering the premium amount:

- Always round up to the nearest whole dollar.
- Enter only the amount for which the participant is responsible. Do not include any amount paid by an employer or other entity. See **Cafeteria or Flexible Benefit Plan** for information on how to determine the amount to include in the cost-effectiveness determination for these types of plans.
- Enter the total amount of the health care premium only.
  - If there are separate premium amounts for dental, vision, or prescription drug coverage, add these amounts to that of the medical premium. Do not determine cost-effectiveness separately for these services, as they are additions to the basic health insurance coverage.
  - If the premium includes other types of coverage (life insurance, disability insurance, etc.), deduct these costs from the premium to establish the cost of the health care coverage.
- Evaluate only the specific premium option that applies to the household being evaluated. The HIPP program will pay only for the option necessary to ensure that the Medicaid-eligible persons are covered. For example:
  - If only single and family options are offered, use the family option.
  - If only the children are Medicaid-eligible, use the employee + children premium option if the employer offers one.
- Use deductibles in the cost-effectiveness determination but not out-of-pocket costs. Add any applicable deductibles for dental or vision coverage to the deductible for medical coverage. Assume the participant will use in-network providers and use those applicable deductibles.
- When a plan has only copayments and no deductibles, leave the deductible field blank.
- When doing an initial cost-effectiveness determination, if the individual or family is not currently enrolled in a plan, evaluate each plan offered by the employer. Give the participant the choice of which cost-effective plan in which to enroll. See **Multiple Plans Available** for more information.
- If the participant is already enrolled in a plan, evaluate only this plan.

Payment of premiums is based on prospective (future) savings for Medicaid. Future savings need to be demonstrated before requiring enrollment in a plan or paying for a plan in which coverage already exists. The HIPP program will not pay premiums for any prior period of time for which cost-effectiveness cannot be demonstrated. See **Effective Date of Premium Payment** for more information.

Entering Data for the System Calculation

When determining cost-effectiveness, all data is entered onto the Cost Effective Determination Policy Information (HICP) screen, as follows:

Step 1 Enter the premium amount paid by the employee, the single and family deductible amounts, the frequency of the premium and check (x) the services covered by the policy. Always round the premium up to the nearest whole dollar. Update and save the information by pressing the **PF4** key. Then press the **PF10** key to go to the HICE screen.

Step 2 On the Cost Effective Determination Eligible Information (HICE) screen, enter the state identification number of the first Medicaid-eligible person to be considered in the cost-effectiveness determination. Save and update the information by pressing the **PF4** key.

To add another person, press **PF9** and then again press the **PF4** key to save and update. Follow this process for each person to be considered in the cost-effectiveness determination.

When all of the eligible persons have been added and the PF4 key has been pressed after the last person added, press the **PF10** key. The system will then make a cost-effectiveness determination.

Step 3 Print both the policy information screen and the final recommendation screen. The system will generate a *Cost Effectiveness Determination* (report S474H056-1) no later than the next business day. Replace the screen prints with the final system-generated report to document the facts on which the application decision was made.

Step 4 File a copy of the *Cost-Effectiveness Determination* (report S474H056-1) in the HIPP case record to document the action taken. Do this even in circumstances when the case is automatically determined cost effective. (See **Deemed Cost-Effectiveness**.)

The "Buy" or "Don't Buy" Recommendation

If the system recommendation is to "buy," based on average Medicaid utilization no further determination is required. If the recommendation is "don't buy," follow these steps:

Step 1 First determine if deducting any added costs for dental, prescription, or vision services may lower the cost. Be sure to eliminate that service from the screen when re-evaluating cost-effectiveness.

If cost-effectiveness can be established by eliminating premiums for these extra services, the HIPP program will reimburse only the basic health insurance premium.

Step 2 If the plan is still determined to be not cost-effective after completing Step 1, investigate the specific health-related circumstances of the persons covered or who could be covered under the plan to determine if any Medicaid-eligible family members have medical conditions that may result in higher-than-average utilization of medical services.

Use form 470-2868, *Health Insurance Premium Payment Medical History Questionnaire*, to obtain this information. If, when returned, this form indicates no unusual or extensive health conditions for Medicaid-eligible persons, deny the application or cancel the case as applicable.

Step 3 If the family has been receiving Medicaid, also review the Medicaid payment history to establish the amount of Medicaid expenditures made on behalf of the family for services that could be covered under the plan. Do not consider the costs of services that would not be covered under the plan or are not expected to continue.

For example, if the Medicaid payment history shows very high expenditures for orthodontia services and orthodontia is not covered by the plan, these expenditures should not be taken into consideration when determining whether higher-than-average utilization is present that would make buying the plan cost-effective.

Step 4 If Medicaid-eligible family members are currently enrolled in the plan being evaluated, obtain a release from the participant using form 470-3951, *Authorization to Obtain or Release Health Care Information.*

Send the release to the insurance company requesting claims payment history for the previous 12 months. Generally, a review of the past 12 months of services is a good indicator of future utilization for ongoing medical conditions.

If the information on the Medicaid payment history or the claims payment history from the insurance company indicates that future utilization of medical services is likely to be higher than average, the IM worker uses the prudent-person concept to override the computer recommendation not to buy the plan.

If the intake clerks are evaluating the cost-effectiveness, they will request assistance from the IM worker in making a decision to override the computer recommendation.

If the IM worker's decision is to pay the premium, the IM worker will set up the case for payment. If the decision is not to override the system recommendation, the clerk will deny the application.

Ms. J, age 32, receives Medicaid for herself, her seven-year-old son, and her two-year-old daughter. Her employer offers group health insurance that covers hospitalization and physician services. Her share of the premium is $250 per month for a family plan.

Based on a comparison of the average Medicaid costs for the services covered under the plan by a family with the same demographic data and the cost of paying the premiums, the plan is determined not cost-effective.

However, after obtaining the *Medical History Questionnaire* and reviewing the Medicaid payment history, it is determined that both children have chronic illnesses that require frequent hospitalization and treatment.

Therefore, even though the plan is not cost-effective based on average utilization for a similar family, the plan is determined cost-effective based on information regarding the specific health-related circumstances of Ms. J's family.

Regardless of the final decision regarding payment of the premium, file a copy of the *Cost-Effectiveness Determination* (report S474H056-1) in the HIPP case record as documentation of the action taken.

When the system recommendation is "don't buy," document in the HIPP file why the recommendation was overridden. Documentation must include:

- A copy of the *Medical History Questionnaire*, form 470-2868.
- Medicaid payment histories.
- Claims history information from the insurance company, if applicable.
- A written narrative.
- Any other pertinent information necessary to document the decision.

See 6-Appendix for a copy of the *Medical History Questionnaire*, form 470-2868, and instructions on how to complete it.

Deemed Cost-Effectiveness

Legal reference: 441 IAC 75.21(3)"a"

Under certain circumstances, some health plans are deemed to be cost-effective and are automatically eligible for payment under the HIPP program. These plans are:

- Group health plans that provide major medical coverage at a cost of:
  - $50 or less per month for one-person Medicaid-eligible person; or
  - $100 or less per month for two or more Medicaid-eligible persons.
- Group health plans that provide major medical coverage when there is a Medicaid-eligible pregnant woman who can be covered by the plan. Individual health plans that cover the pregnant woman must meet the usual system-determined cost-effectiveness test.

Multiple Plans Available

Legal reference: 441 IAC 75.21(8)

When more than one cost-effective health insurance plan is available, the HIPP program will pay the premium for only one plan. The participant may choose in which cost-effective plan to enroll.

When there is more than one plan available to the participant, complete a cost-effectiveness determination on each available plan. If more than one plan is determined to be cost-effective, notify the participant that the participant may choose between the plans. If only one plan is cost-effective, request the participant to enroll in that plan.

PREMIUM PAYMENT

Legal reference: 441 IAC 75.21(9)

Before premium payment can be issued for a health plan that has been determined cost-effective, verification of the cost of the premium must be provided as follows:

Group health plans: For group health plans, the case record must contain form 470-3036, *Employer Verification of Insurance Coverage*, completed by the employer. This form:

- Verifies:
  - The amount and frequency of the premium payment,
  - The effective date of the coverage,
  - The persons covered by the plan, and
  - The insurance company name and claims address.
- Identifies the employer's choice of payee (whether the HIPP program pays the employer directly or reimburses the employee for payroll deduction).

If the employer will not provide the verification directly to the HIPP Unit, the participant may verify the information by providing copies of pay stubs and other information to verify the persons covered and the effective date of the insurance. If other information is used for verification instead of the *Employer Verification of Insurance Coverage*, the reason why the additional information was necessary must be thoroughly documented in the case record.

Once the ongoing HIPP case is established, the IM worker requests a current pay stub from the participant for confirmation of the deduction withheld from the paycheck. The IM worker compares the pay stub deduction to the employer's verification and resolves any discrepancies by contacting the employer.

COBRA plans: For COBRA continuation plans, the case record must contain form 470-3037, *Employer Verification of COBRA Eligibility*.

Individual health plans: For individual health plans, the case record must contain a current premium notice establishing the amount of the premium and the frequency it is paid, as verification of the cost. Additional verification of past premiums paid must be obtained before issuing a retroactive payment.

Effective Date of Premium Payment

Legal reference: 441 IAC 75.21(9)

The effective date of premium payment is determined by several factors. When determining the effective date on which premium payments can begin, consider the following:

- Whether the plan is a group health plan or an individual health plan.
- The date the plan becomes cost-effective.
- The date there was Medicaid-eligible persons covered by the plan.
- The date on which the HIPP Unit receives the HIPP application.

Premium payments begin no earlier than:

- The first day of the month in which the HIPP Unit of the Division of Financial, Health, and Work Supports receives the application (the HIRF electronic referral; form 470-2844, *Employer's Statement of Earnings*; or form 470-2875, *Health Insurance Premium Payment Application*) or the first day of the first month in which the plan is cost-effective, whichever is later.
- If the Medicaid-eligible persons are not enrolled in the plan when HIPP eligibility is established, premium payments begin in the month in which the first premium payment is due after enrollment occurs.

- If there was a lapse in coverage during the application process (e.g., the plan is dropped and re-enrollment occurs at a later date), premium payments are not made for any period before the most recent effective date of coverage.
- In order to make retroactive premium payments, there must be HIPP eligibility on the date of approval. No payment will be made for any previous period if ongoing HIPP eligibility is denied.
- Payments cannot be made for premiums that were used as a deduction to income when determining client participation or spenddown for Medicaid eligibility.

1. Ms. M, a Medicaid recipient, becomes employed April 20 and enrolls in the employer's group health plan effective May 1. The HIPP Unit receives the *Employer's Statement of Earnings* on May 10. The plan is determined cost-effective and approved for premium payment.

   Ms. M is reimbursed for premiums paid since May 1, the date of enrollment. Because her HIPP application was received in May, any payments made since the beginning of May will be reimbursed.

2. Same as Example 1, except the insurance plan is determined to be not cost-effective and HIPP eligibility is denied. On June 5, Ms. M reports that due to renegotiation of the union contract, the insurance plan covers a broader range of services beginning June 1.

   The plan is determined cost-effective based on the new information. Ms. M is eligible for premium payment beginning June 1, the month in which the plan became cost-effective.

3. Ms. G has had an individual health plan through Blue Cross/Blue Shield of Iowa for several years. Ms. G files a *Health Insurance Premium Payment Application* on March 4. On April 1, the plan is determined cost-effective. Premium payments begin March 1, the first of the month in which the application was received.

4. Same as Example 3, except that Ms. G is not currently enrolled in the insurance plan. Ms. G says she will enroll if the Department will pay the premiums. Since the plan is cost-effective, upon verification of enrollment, premium payments begin with the first premium due.

Methods of Premium Payment

Generally, it is best to pay the employer or health plan directly for health insurance premiums. However, this is not always possible given the specific circumstances of the household and the preferences of the employer or health plan.

- **Group health plans:** Make payment (at the employer's discretion) either directly to the employer to circumvent a payroll deduction or reimburse the employee for payroll deductions. The employer's choice of payment method will be indicated on form 470-3036, *Employer Verification of Insurance Coverage*.
- **COBRA plans:** Payments may be made to the employer or directly to the insurance company, as directed by the employer.

  Only when payment cannot be made to the insurance company or employer should COBRA payments be made to the participant. If it is necessary to pay the participant directly for COBRA premiums, the case record narrative must be thoroughly documented to support the decision to pay the participant.

  This situation might occur, for example, if HIPP reimbursement was being made only for the employee + children option, but the employee was actually paying the family premium to the insurance company.

  If there are time constraints that necessitate paying the participant until payment can be directed to the employer or to the insurance company, begin the process of establishing an ongoing payment to the participant and thoroughly document the need for prompt payment in the case record narrative. Payment to the employer or insurance company should then begin with subsequent payments.
- **Individual health plans:** Payment for individual plans should be made directly to the insurance carrier when possible. This method requires adding the insurance carrier to the vendor file with a signed W-9 form for the insurance company, as indicated below for payment to an employer.

  When verification indicates that premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, reimburse the participant for these withdrawals.

Making Direct Payments to Employers and Insurance Carriers

Before the Iowa Department of Revenue will issue a state warrant to pay an employer or insurance company directly, that employer or insurance company must first be set up on the Department of Revenue's computer system, the I/3, as a vendor. If the employer or insurance company is not already showing on this system:

1. Obtain the federal tax ID number and name of the company or employer and the address where payment is to be made. This information is usually indicated on form 470-3036, *Employer Verification of Insurance Coverage*, when paying the employer directly. If paying the insurance company directly, contact the insurance company for this information.

2. Obtain a completed and signed form 625-1366, *Substitute W 9/Vendor Update Form*, from the employer or insurance company.

3. Submit the *Substitute W 9/Vendor Update Form* to the Department's Bureau of Purchasing, Payments, and Receipts.

Premium payments can be issued once the I/3 system has been updated to reflect the employer or insurance company as a valid vendor.

Premium Amount Paid by the HIPP Program

The amount of the premium that can be paid by the HIPP program is determined by several factors. These factors include, but may not be limited to

- The type of health plan;
- The options available to the participant, such as single, employee plus one person, employee and children, family, etc.;
- The amount and type of employer contribution; and
- The persons enrolled in the health plan compared to those on which cost-effectiveness was based.

Under the HIPP program, only the premium for the available option that will cover the Medicaid-eligible persons in the household while at the same time not creating a financial burden for the household can be paid.

Traditional Employer Plan

A "traditional" employer plan is one in which the employer offers health care coverage to the employee and possibly to the employee's dependents. The employer may pay all or a portion of the cost of the premium. The remaining cost, if any, is usually deducted from the employee's paycheck.

The HIPP program pays only that portion of the premium that is actually paid or owed by the employee (the participant) to provide coverage to the Medicaid-eligible family members. The HIPP program will **not** reimburse any portion of the premium **paid by the employer**.

Cost-effectiveness determinations are made using only the needs of the Medicaid-eligible persons who are or who can be covered by the plan. When a health insurance plan is determined cost-effective based on consideration of the needs of the Medicaid-eligible persons, the HIPP program will pay the cost of the premiums necessary to have those eligible persons covered.

The premium cost for non-Medicaid-eligible household members covered by the plan will be paid only if the cost of that member must be paid to have the Medicaid-eligible persons covered.

For example, if the employer offers only the choice of single or family coverage and one child in the family is Medicaid-eligible, determine cost-effectiveness based on the cost of family coverage, but use only the one child's needs. If cost-effective, HIPP will pay the family premium.

See **ESTABLISHING COST-EFFECTIVENESS** for more information.

Cafeteria or Flexible Benefit Plan

A cafeteria or flexible benefit plan (sometimes called a 'defined contribution plan') is one in which the employer makes a pre-determined amount of money available for the employee to apply towards the cost of the benefits offered by the employer.

Employers may have guidelines under which the funds must be applied, or the employee may have complete discretion on how to apply the funds, including options to take the funds in salary instead of applying them towards benefit costs.

For those individuals participating in a cafeteria or flexible benefit plan, any amount provided by the employer in the form of flexible benefits which is intended to be used for health insurance shall **not** be considered for reimbursement by the HIPP program.

Enrolled in Plan at HIPP Application

If the employee is already enrolled in a flexible benefits plan, request a "Confirmation of Benefits" statement from the employee. The employer provides this statement to the employee.

Total the cost of all benefits chosen by the employee that are subject to subsidy by the flex credits, then subtract the total flex credits allowed by the employer. The balance is the amount used by the HIPP program to determine the cost-effectiveness of the plan and the amount eligible for reimbursement under the program.

Even if the employee has chosen to apply flex benefits to health insurance in lieu of cash salary, HIPP will use the flex credits as applied in determining cost-effectiveness of the plan.

> Ms. C applies for the HIPP program. She is currently enrolled in the family option of her employer-sponsored health plan. Her share of the cost of the family plan is $800 per month.

Ms. C's *Confirmation of Benefits* statement provided by the employer shows that she has also chosen life insurance at $10 per month and disability insurance at $5 per month. The statement also shows that the employer provides $500 per month in flexible benefits to Ms. C. The statement shows that these benefits may be applied to any type of insurance offered by the employer.

The HIPP program will determine cost-effectiveness based on the following:

Total benefits chosen by Ms. C:	Medical insurance	$ 800.00
	Life insurance	10.00
	Disability insurance	5.00
	Total	$ 815.00
Flex benefits provided by employer		- 500.00
Net cost to Ms. C for health insurance:		$ 315.00

HIPP eligibility and determination of the net cost to the insured will always be based on the best information available, usually in the form of a statement from the employer.

Not Enrolled at HIPP Application

If the participant is not enrolled in any plan when application for the HIPP program is made, determine whether enrollment in any option would be considered by the employer to be a reduction in salary.

In any case where a statement from the employer confirms that these flex benefits would be available to the participant as cash salary in the absence of a benefit choice, use the total cost of the least costly available option and apply no flex credits when determining cost-effectiveness of the plan.

If the HIPP program requires enrollment in the plan, the cost will be looked at as a cost for enrollment and, as such, must be used to determine cost-effectiveness and payment, if cost-effective.

If there is no indication from the employer that the participant may choose to receive flex benefits in cash in place of using them for insurance coverage, then proceed to determine cost-effectiveness based on the least costly option available and apply all available flex credits to that option.

When Ms. J applies for the HIPP program, she is not currently enrolled in the insurance plan offered by her employer. Ms. J's household consists of her spouse, who is not eligible for Medicaid, and two children, both of whom are eligible for Medicaid. Information from the employer indicates that the monthly cost of insurance would be:

Single:	$250
Employee/children:	$375
Family:	$500

Ms. J's employer indicates that flex benefits of $250 per month are available to Ms. J. These benefits must be applied to the cost of health insurance. If Ms. J chooses not to elect health benefits, no part of the flex benefit will be available to Ms. J as a cash benefit.

The HIPP worker determines cost-effectiveness based on the employee/children premium of $375 - $250 in flex benefits. The resulting premium of $125 per month is determined cost-effective. The HIPP worker requests that Ms. J enroll in the employee/children option of her health insurance at a net reimbursable cost of $125 per month.

COBRA Plan

For COBRA policies, the HIPP program will pay the cost of the premium charged to the participant to cover the Medicaid-eligible persons. The cost charged to the participant will include the employer portion of the cost and in some cases a 2% administrative charge. If the plan allows, the HIPP program will pay only the cost of the COBRA option that will cover the Medicaid-eligible persons.

Individual Plan

For an individual plan, the HIPP program will pay that part of the participant's premium that must be paid in order to cover the Medicaid-eligible persons on the policy. If the premium cannot be broken down to pay only for the Medicaid-eligible persons, HIPP will pay the family premium, if it is cost effective.

Frequency of Payment

Premium payments are generally made on the same frequency on which they are owed. This may be:

- The schedule on which premiums are deducted from the participant's wages; or
- The frequency on which direct payments to an insurance company must be made.

When establishing the schedule on which to issue premium payments, it is important to review carefully how often the insurance premiums are withheld or are otherwise due, so that payments are made on time and in the correct amount. Failure to issue premium payments correctly may result in cancellation of the coverage for non-payment or untimely payment of premiums, overpayments, or underpayments.

The HIMM system will continue to issue payments on the schedule established by the IM worker until otherwise notified to discontinue payment.

HIPP program payments can be issued on any of the following schedules:

- Annually (one time per year)
- Semi-annually (two times per year)
- Quarterly (four times per year)
- Monthly (one time per month)
- Semi-monthly (twice per month)
- Weekly (52 weeks per year)
- Bi-weekly (26 times per year)
- Weekly (48 weeks per year)
- Bi-weekly (24 times per year)

When **paying an employer directly** in order to circumvent a payroll deduction, make payment on the schedule indicated by the employer on form 470-3036, *Employer's Verification of Health Insurance*.

When **reimbursing a participant** for a payroll deduction, use the schedule indicated on form 470-3036, *Employer's Verification of Insurance Coverage*, to coincide with the payroll deduction. Set up the case to issue payment five working days before date of the payroll deduction in order to ensure that the participant receives the reimbursement on or close to their payday.

When paying premiums **directly to an insurance company**, pay on the schedule required by the insurance company. Make sure to establish the issuance dates so that the payment will be received by the insurance company before the premium due date so that the coverage does not lapse.

When paying **COBRA premiums**, pay on the schedule indicated by the employer on form 470-3037, *Employer Verification of COBRA Eligibility*. In most cases, premiums for COBRA continuation coverage may be paid either to the employer or the health plan.

Discontinuing Premium Payment

Legal reference: 441 IAC 75.21(7)

Discontinue payments under the HIPP program when changes in the cost, benefits, or the number of Medicaid-eligible persons in the household affect the ongoing cost-effectiveness of the plan. See **ACTING ON CHANGES** for additional information.

The following sections give more information on discontinuing payments when:

- The household loses Medicaid eligibility
- The health plan is determined to be no longer cost-effective
- The health plan is no longer available

Loss of Medicaid Eligibility

Payment of premiums under the HIPP program is a category of service under Medicaid. In order for payments to be made, there must be at least one Medicaid-eligible person in the household that is covered by the health plan.

However, any premium payment that becomes due in a month in which there is Medicaid eligibility is eligible for payment if all other eligibility factors are met, regardless of what time period the premium is intended to cover.

Ms. T is participating in the HIPP program. Insurance premiums are due on the fifteenth of each month for the next month's coverage.

On December 8, the HIPP worker is informed that Ms. T's Medicaid eligibility will be canceled as of January 1. The December premium is paid, even though it is intended to cover the month of January.

At system month-end, the HIPP system accesses the activity file on the ABC system to identify any HIPP cases that are being canceled from Medicaid. See **REPORTS** for additional information.

When the entire household loses Medicaid eligibility, premium payments are discontinued as of the month of Medicaid ineligibility. The 10-day notice action from the local office automatically triggers the HIPP system to:

- Generate form 470-0485, *Notice of Decision*, to the participant with copies to the local office and the HIPP worker.
- Shut down the case on the HIMM system.

File a copy of the notice in the HIPP case record file. See **NOTICE REQUIREMENTS** for more information.

For situations in which the local office terminates Medicaid eligibility with only adequate notice, the HIPP system produces a report, *HIPP Cases Changed to Inactive Status* (S474H058-1). All monthly closings are reported here.

In some instances, it is necessary to hand issue a HIPP program cancellation notice (i.e. when Medicaid ends because a transitional medical case reaches its expiration date). The HIPP worker will determine from report S474H058-1 which cases require an adequate notice to cancel HIPP program benefits. See **REPORTS** for more information.

Plan No Longer Cost-Effective

Changes in the cost, the covered benefits, or the number of Medicaid-eligible persons covered by the health plan can affect the ongoing cost-effectiveness. Review cost-effectiveness any time any of these factors change.

If the result of the redetermination is that payment of the premium is no longer cost-effective, the HIPP worker shall follow the procedures for a final cost-effectiveness determination found under **ESTABLISHING COST-EFFECTIVENESS**. If the insurance plan continues to be cost-effective, continue premium payment.

If the change in the household results in the plan no longer being cost-effective, make system entries to discontinue premium payments. Send the household a timely and adequate notice before discontinuing payment. File a copy of the notice in the HIPP file and close the case. See **NOTICE REQUIREMENTS** for more information.

If the HIPP program case remains active, but there is a change in the number of Medicaid-eligible persons, report S474H266-1, *Active HIPP Cases on Which Medicaid Eligibility Was Lost*, is generated to the IM worker. Review the case to determine what effect, if any, the change in the household had on cost-effectiveness.

Health Plan No Longer Available

If the insurance coverage has ended, enter a policy end date on the system. Send the household an adequate notice and file a copy of the notice in the HIPP case record. See **NOTICE REQUIREMENTS**.

If HIPP program payments were made after the coverage end date, an overpayment may have occurred. Refer to **OVERPAYMENT AND RECOUPMENT** for more information.

NOTICE REQUIREMENTS

Legal reference: 441 IAC 75.21(13), 441 IAC 7.7(1)

Issue an adequate notice to describe the action being taken on the HIPP application or case. If benefits are being reduced or canceled, the notice must also be timely, as noted below. In some situations, the HIMM system automatically generates a notice of decision. In other situations, the worker must make system entries to generate the notice.

- Use form 470-2845, *Notice of Health Insurance Premium Payment*, to notify the household that the Department will pay the health insurance premium. This form is worker-generated from the HIANMAP screen of the HIMM system. The form identifies:
  - The Medicaid-eligible persons for whom the premium is being paid
  - The date premium payments will begin
  - The amount of the payments
  - The frequency of the payments
  - Specific information regarding the insurance carrier
- Use form 470-2847, *Denial of Health Insurance Premium Payment*, to notify the household that the Department will not pay the health insurance premium. This notice is generated by an entry on the Denial Notice Request screen found on the Denial/Tickler sub-menu of the HIMM system.

  In most cases, the intake clerk handling the application will generate this notice and will enter the IM worker's initials, after entering the intake worker's own name and phone number. This action ensures that any appeals will be directed to the IM worker for response.

  Calls or other inquiries from customers regarding the notice will be directed to the intake clerk who made the decision and has the application.
- Use form 470-2846, *Cancellation of Premium Payment*, to notify the household and the employer, if appropriate, of the decision. Four copies of the notice are generated, one each for the participant, the local office, the employer (if applicable) and the HIPP Unit.

The following sections explain when to issue:

- An "adequate" notice
- A notice that is both "adequate" and "timely"

Adequate Notice Required

Issue an "adequate" notice of decision:

- To inform the household of the initial decision on cost-effectiveness and premium payment, whether approval or denial.
- To inform the household that premium payments are being discontinued because:
  - The policy is no longer available (e.g., the employer or participant drops insurance coverage, the insurance company terminates the policy, or the job or insurance ends).
  - All persons covered under the policy have lost Medicaid eligibility.

Since HIPP payments are a category of service under Medicaid, it is not necessary to issue a separate timely notice of decision for HIPP in addition to the timely notice of cancellation issued by the local IM worker notifying the family of the Medicaid cancellation.

The HIPP worker must hand-issue adequate notice of cancellation by whenever report S474H058-1, *HIPP Cases Changed to Inactive Status*, indicates loss of Medicaid by all persons covered on the policy.

Timely and Adequate Notice Required

Issue a timely and adequate notice of decision:

- To inform the household that the premium payments are being reduced.
- To inform the household that the premium payments are being discontinued because:
  - The participant is no longer in the home; or
  - The policy is no longer cost-effective; or
  - The participant has failed to provide necessary information to establish ongoing eligibility (failed to return a review form, etc.).

COOPERATION

Legal reference: 441 IAC 75.21(1)

Cooperation in establishing the availability of group health insurance and enrollment in a group health plan that has been determined cost-effective is a condition of Medicaid eligibility.

Failure to Cooperate

Unless good cause for failure to cooperate is established, Medicaid benefits of the employed participant shall be terminated when a participant:

- Fails to provide information necessary to determine availability and cost-effectiveness of group health insurance. Exceptions:
  - Medicaid benefits of a child shall not be canceled due to a parent's failure to cooperate.
  - Medicaid benefits of the spouse of the employed person shall not be terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.
- Fails to enroll in a group health insurance plan that has been determined cost-effective. Ineligibility for Medicaid will continue until the participant completes enrollment or it can be established that the group health insurance plan is no longer available.
- Disenrolls from a group health insurance plan the Department has determined cost-effective. When it is established that the participant disenrolled from a cost-effective plan and did not enroll in another cost-effective plan, Medicaid benefits of the participant will be canceled until the participant enrolls in the plan. This policy applies even when enrollment is allowed only during open enrollment periods.

The intake clerk shall notify the local office of the noncooperation using form 470-0409, *Medicaid Notice of Sanction*, if, during the HIPP application process, the applicant:

- Fails to cooperate in establishing availability or cost-effectiveness of a group health plan;
- Fails to enroll in a plan that has been determined cost-effective; or
- Disenrolls from a cost-effective plan.

If disenrollment occurs when there is an active HIPP case, the IM worker responsible for the case shall notify the local office of the non-cooperation using the same form. See 8-C, **Cooperation With the Health Insurance Premium Payment (HIPP) Unit**.

Good Cause for Failure to Cooperate

Medicaid benefits of the employed participant shall not be terminated when good cause for failure to cooperate is established. Good cause for failure to cooperate with the HIPP program is established when the HIPP applicant or participant demonstrates that one or more of the following conditions exists:

- There was a serious illness or death in the HIPP applicant's family.
- There was a family emergency or a household disaster, such as a fire, flood, or tornado.
- The participant offers a good cause beyond the participant's control.
- There was a failure to receive the Department's request for information or notification for a reason not attributable to the HIPP applicant or participant.

The applicant or participant may be given additional time to cooperate when good cause is determined to exist. However, the presence of good cause does not relieve the parent of the requirement to cooperate.

Satisfying the Sanction

When a member of the HIPP staff (either an IM worker or an intake clerk) determines that the HIPP participant has cooperated, that staff member shall notify the local office via e-mail that the non-cooperation has been satisfied and the local office can lift the sanction of Medicaid benefits.

In addition, whenever HIPP staff becomes aware that the HIPP participant is no longer employed by the employer who offered the insurance plan for which the sanction was imposed, the HIPP staff member will notify the local office via e-mail that the sanction can now be lifted.

ACTING ON CHANGES

Legal reference: 441 IAC 75.21(11)

A HIPP participant shall reported changes in the participant's circumstances that affect the availability or cost-effectiveness of the policy within ten calendar days from the date of the change. Changes may be reported by telephone, in writing, or in person. Form 470-3007, *HIPP Change Report*, shall accompany all premium payments to facilitate change reporting.

The IM worker shall take action to verify, document, and notify the household of the impact of the change on the household's HIPP program eligibility for all reported changes. The type of action the IM worker takes on a change may depend on whether the change was reported timely or untimely.

The IM worker shall act on all reported changes as soon as possible and within five working days of receipt of the notification of the change. Acting on reported changes may include requesting additional information or verification necessary to determine how the change affects HIPP eligibility.

When a change is reported that may also affect the Medicaid case, the HIPP worker shall notify the local IM worker to ensure both are aware of the change. Examples of changes that should be reported to the local IM worker include, but are not limited to:

- Address change
- Loss of employment
- Changes in household members

The following sections give instructions on how to handle:

- Premium changes reported timely
- Premium changes that are not reported timely
- Loss of Medicaid eligibility
- Changes in health insurance carrier
- Unborn and newborn children
- Reinstatement of HIPP eligibility
- A participant leaving the home
- Loss of employment
- Warrants returned by the post office

Premium Changes Reported Timely

If an increase or decrease in the premium is reported before the effective date of the change or within the 10-day reporting period, the IM worker shall:

1. Verify the change. The change may be verified by contact with the employer or with a pay stub provided by the HIPP participant that shows the amount being deducted.

2. Determine if any additional amount is owed or whether an overpayment has occurred:

   - If an additional amount is owed, issue a supplemental warrant ("special") to the participant. The payment will be effective with the date of the change. Issue the back payment without regard to the continued cost-effectiveness of paying the new premium.

   - If an overpayment has occurred, reduce the amount of the next premium issued.

3. Change the ongoing premium to be issued in the HIMM system.

4. Review current Medicaid eligibility for all covered persons to establish who should be included in the cost-effectiveness determination.

5. Complete a cost-effectiveness determination after the ongoing premium is changed and the supplemental payment issued, if applicable.

6. Make the appropriate system entries and notify the participant of the result of the cost-effectiveness determination.

7. Send form 470-0485, *Notice of Decision*, to the participant. This form is generated through the system from the Change Notice Request screen, found on the notice sub-menu of the HIMM system. File a copy of the notice and accompanying documentation in the case record.

8. Narrate the progress notes in the case record to document the action taken.

Premium Changes Not Reported Timely

If an increase or decrease in the premium is not reported before the effective date of the change or within the 10-day reporting period, the IM worker shall:

1. Verify the change. The change may be verified by contact with the employer or with a pay stub provided by the HIPP participant that shows the amount being deducted.

2. Issue a timely and adequate notice of decision to the participant if the reported change results in a decrease of HIPP benefits, and decrease the reimbursement amount on the HIMM system accordingly.

3. Issue payment for any underpayment of premium reimbursement.

   - When the participant is the payee, issue payment **only** effective with the first of the month in which the change was reported.
   - If the employer or insurance company is the payee, issue the balance of any premium reimbursement underpayment due back to the point of the change, regardless of when it was reported.

4. Review current Medicaid eligibility for all covered persons to establish who should be included in the cost-effectiveness determination.

5. Complete a cost-effectiveness determination after the on-going premium is changed and the underpayment issued, if applicable.

6. Make the appropriate system entries and notify the participant of the result of the cost-effectiveness determination.

7. Determine if an overpayment has occurred. If so:

   - Reduce the amount of the next premium payment to recover the overpayment; or
   - Initiate recovery. See **OVERPAYMENT AND RECOUPMENT** for more information.

8. Send a *Notice of Decision*, form 470-0485, to the participant. This form is generated through the system from the Change Notice Request screen, found on the notice sub-menu of the HIMM system. File a copy of the notice and accompanying documentation in the case record.

9. Narrate the progress notes in the case record to document the action taken.

Loss of Medicaid Eligibility

When the entire household loses Medicaid eligibility, discontinue premium payments as of the month of Medicaid ineligibility. When only part of the household loses Medicaid eligibility, review cost-effectiveness to determine whether premium payments should continue.

All Members Lose Medicaid Eligibility

At system month-end, the HIPP system accesses the activity file on the ABC system to identify any HIPP cases on which all persons are being canceled from Medicaid. For these cases, the HIPP system automatically:

- Generates a *Notice of Decision* to the HIPP participant, notifying the participant that HIPP payments are ending. Copies of the notice are sent to the local IM worker, the employer, and the HIPP worker.
- Closes the case.

When the entire household loses Medicaid eligibility, the IM worker shall:

1. Review report S474H058-1 *HIPP Cases Changed to Inactive Status*, to ascertain whether a *Notice of Cancellation* was system-generated. It may be necessary to manually generate a cancellation notice.

   For example, when Medicaid eligibility was lost due to transitional Medicaid ending, the local IM worker does not issue a notice at the time of closure because the family was informed at the beginning of the transitional period when Medicaid would end. In this case, issue a cancellation notice for the HIPP case as a courtesy.

2. File the *Notice of Decision* or HIPP *Notice of Cancellation* in the case record.

3. Narrate the progress notes in the case record to document the action taken.

Part of Household Loses Medicaid Eligibility

When only part of the household loses Medicaid eligibility, the HIPP system generates a monthly report, *Active HIPP Cases on Which Medicaid Eligibility Was Lost* (S474H266-1), to inform the IM worker of the need to recalculate cost-effectiveness. See **REPORTS** for more information. Upon receipt of the report, the IM worker shall:

1. Complete a cost-effectiveness review to determine whether payment of the premium continues to be cost-effective. See **ESTABLISHING COST-EFFECTIVENESS** for additional information.

2. Issue an appropriate notice of decision, based on the outcome of the cost-effectiveness determination. See **NOTICE REQUIREMENTS** for more information.

3. Make appropriate system entries to close the case if it is no longer cost-effective.

4. File the notice of decision and all documentation regarding the action taken in the case file.

5. Narrate the progress notes in the case file to document the action taken.

Changes in Health Insurance Carrier

When the HIPP Unit becomes aware that the employer has changed insurance carriers, the IM worker shall:

1. Leave the existing HIPP case open pending a cost-effectiveness determination of the new plan.

2. Request the participant to provide verification of the new plan information by sending form 470-3036, *Employer Verification of Insurance Coverage*. Follow the procedures outlined in **Failure to Cooperate** if the requested verification is not returned.

3. Complete a review of HIPP eligibility, including a cost-effectiveness determination, using the new information.

   New Plan Cost Effective

   If the new plan is cost-effective, the IM worker shall:

   - Enter the insurance ending date and close down the existing case on the HIMM system.
   - Set up a new case with the new carrier on the HIMM system.
   - Issue a change notice to the participant from the Change Notice Request (HIMMCNR) screen of the HIMM system if this action is being taken at the same time that the old insurance carrier information is ending. The notice informs the participant of:
     - The effective date of the change,
     - The new carrier, and
     - The new premium amount, if applicable.

     If you have previously sent a cancellation notice on the old information, send a new approval notice for this carrier.
   - File the copy of the notice of decision and accompanying documentation in the case record.
   - Narrate the progress notes in the case record to document the changes and action taken.

New Plan Not Cost Effective

If the new plan is not cost-effective, the IM worker shall:

- Cancel the HIPP case if not previously done. See **ESTABLISHING COST-EFFECTIVENESS** for steps that need to be followed.
- Issue a notice of decision regarding the action being taken. This will be a cancellation notice if it has not already been sent or a denial notice for the new plan if the cancellation has already been sent.
- File the copy of the notice of decision and accompanying documentation in the case record.
- Narrate the progress notes in the case record to document the action taken.

Please note: Any HIPP payments made in error because the change in carriers was not reported or verified in a timely manner are subject to overpayment recovery.

Unborn and Newborn Children

The IM worker shall make every effort to track the birth of babies to pregnant women for whom premiums are being paid. It is essential that the IM worker becomes aware of the birth as soon as possible, since most health plans allow only 30 days from the date of birth to add the new baby to an existing policy.

This process begins with the application when it is established that there is a pregnant woman who can be covered by the health insurance plan. Since group health plans that provide coverage to a pregnant woman are deemed cost-effective, the expected due date and the actual birth date need to be tracked.

Unborn Children

When there is a pregnant woman in the household being approved for HIPP payment, the IM worker shall:

- Send the HIPP form letter entitled *Important Notice for Pregnant Women*. This notice advises the household of its responsibility to report the birth of the baby within 10 days of the birth. Send this letter when the HIPP case is initially established or when the HIPP Unit becomes aware that there is a pregnant woman on an existing case.
- Track the expected birth by creating a tickler report which will be sent to the worker at the time of the expected due date. This tickler reminds the IM worker to check to see if the birth of the baby has occurred.
- Review monthly report C474H268-1, *HIPP Eligibles with Unborn/Newborn Indicator on ABC*. Use this report as a reminder to continue to check on the status of the birth. Although the participant is expected to report the birth, every effort to track the birth must be made so that the opportunity to add the baby to the insurance plan is not missed when it is cost-effective to do so.

Newborn Children

When the IM worker becomes aware that the baby has been born and added to Medicaid, the IM worker shall:

- Complete a cost-effectiveness determination that includes using both the mother and the newborn baby as well as any other Medicaid-eligible persons covered by the plan. Use the 0-60 days category for the newborn. Remember: If the cost of buying the health insurance plan will increase by adding the baby, enter the premium amount that will apply if the baby was added.
- Notify the participant to add the baby to the plan when the result of the calculation is that it is cost-effective to add the baby to the insurance plan.
- Generate a change notice to the participant from the Change Notice Request (HIMMCNR) screen of the HIMM system if the result of the calculation is that adding the baby is not cost-effective.
- Narrate the case record to document the action taken.

Ongoing Cost-Effectiveness Determinations for Newborns

When one or more members of the covered eligible group loses Medicaid eligibility and the covered group includes a newborn child, the IM worker shall:

- Recalculate cost-effectiveness. In doing the cost-effectiveness determination, continue to use "age 0-60 day" costs for the newborn.
- Continue payment for a period of six months from the date of birth if the health plan continues to be cost-effective.
- Establish a review date for the end of the six-month period. When this review date is reached, recalculate cost-effectiveness again using "age 1" costs for the child.
- Notify the participant of the result. If the plan is no longer cost effective, cancel the case and issue a timely and adequate notice of decision. If the plan remains cost-effective, issue a change notice showing a review has been done and there are no changes.
- Narrate the case record to document the action taken.

Reinstatement of HIPP Eligibility

Legal reference: 441 IAC 75.21(15)

When HIPP benefits have been canceled because the participant fails to cooperate in providing information necessary to establish continued eligibility for the HIPP program, reinstate benefits the first day of the first month in which the participant cooperates.

Mr. K is canceled from HIPP participation effective July 31 because he did not return his review form which was due on July 9. On September 2, Mr. K returns the review form and the HIPP worker completes the review and determines that the case is still eligible.

The HIPP worker then issues payment for any premium that should have been issued in September. No premium is issued for August, because the necessary information was not provided until September.

If HIPP benefits have been canceled because Medicaid eligibility is canceled and reinstated within the same month, the HIMM system will automatically issue a reinstatement notice of decision and reinstate HIPP payments with no break in the issuance.

When HIPP benefits have been canceled because all persons covered under the policy have lost Medicaid eligibility and Medicaid eligibility is subsequently re-established, reinstate HIPP payments, if all other eligibility factors are met. This is true regardless of whether Medicaid was reinstated or a new Medicaid application was filed and approved.

The IM worker is usually notified of the re-establishment of Medicaid eligibility through report S474H057-1, *Persons Changed to TXIX Eligible on HIPP Cases Where Payment Has Ended/Will End*. This report identifies HIPP participants who have been canceled in the previous three months due to the loss of Medicaid eligibility but who currently have Medicaid eligibility. See **REPORTS** for more information.

The following procedure applies to reinstating a HIPP case manually. It does not apply to cases that are reinstated automatically when Medicaid eligibility was lost and then regained within the same month.

When reinstating HIPP eligibility, the IM worker shall:

- Check IABC screens for Medicaid-eligible members and possible address changes.
- Verify with the employer whether insurance coverage is still in effect and whether there have been any changes (same plan, premiums, etc.). Skip this step if the break in HIPP coverage has been less than one month.
- Complete a cost-effectiveness determination based on the current Medicaid-eligible persons in the household, premiums, and coverage. If the reinstatement is done within 30 days of the cancellation, the new cost-effective determination is needed only if any of the factors have changed.
- If cost-effective, re-open the HIPP case. On the Premium Payment Detail Information (HIPPMAP) screen, enter 9s in the ENROLLMENT EXPIRATION field. Enter the NEXT ISSUE date and the "PAY/PREM" date, enter "Y" in the CONT. ENROLL field, and press the **PF04** key to update.
- Calculate and issue any back payment due to the participant, if applicable.

- Issue a reinstatement notice to the participant, adding a note concerning any back payment issued.
- Narrate the progress notes of the case record.
- Continue payment of the HIPP premium until all steps in determining cost-effectiveness are completed. Once all steps have been taken and the result is that the plan is no longer cost-effective, cancel the case with 10-day notice.

If opening a HIPP case 30 or more days after it was closed for loss of Medicaid, the *Reinstatement Review* form may be used. See **Reinstatement Reviews**. Narrate in the case record, "Reinstatement review completed." Change the review date on the system to indicate a review was done on the current date.

Regardless of whether or not this is used as a reinstatement review, all eligibility factors must be verified and narrated in the case record before the reinstatement can be completed.

Participant Leaves the Home

The participant must live in the home with the Medicaid-eligible persons in order for premiums to be paid through the HIPP program. Since the Child Support Recovery Unit is responsible for the enforcement of child and medical support for Medicaid-eligible children, the HIPP program cannot pay health insurance premiums that are the responsibility of, or potentially the responsibility of, an absent parent.

This policy does not apply when the potential of medical support enforcement is not present. For example, if the participant is maintaining coverage on a disabled adult child, the participant does not have to live in the home.

When the participant leaves the Medicaid household, the IM worker shall discontinue premium payments and issue a timely and adequate notice of decision.

Initiate recoupment when you become aware, after the fact, that the participant has left the home. Make every attempt to verify the date the participant left in order to establish the amount of misspent HIPP premiums.

Loss of Employment

Once notice is received that employment is ending or has ended, the IM worker shall:

- Verify with the employer:
  - When employment ended.
  - When insurance coverage will end.
  - When the last deduction was taken from the paycheck (if reimbursing the participant).
  - Whether the participant is eligible for COBRA coverage.
  - The cost of COBRA, if applicable.

  You may request this information from the employer verbally or in writing. If requested in writing, track it for response. If no response is received within ten days of the request, follow-up with a phone call to the employer.
- Enter the enrollment expiration date on the Premium Payment Detail Information (HIPPMAP) screen. This will usually be the current date.

  After you receive verification of the date of the last payroll deduction from the employer, you may determine that another warrant needs to be issued to make reimbursement for the final payroll deduction. If so, the enrollment expiration date will be the day after that final warrant is to issue.
- Enter the ending date of the policy on the Policyholder Detail Information (TPPDMAP) screen. This date will be re-opened if COBRA coverage is approved.
- Issue a notice of cancellation. Since the determination to pay the premiums under COBRA may take some time, the ongoing HIPP case should be canceled and the household notified of the pending COBRA eligibility determination, if applicable.
- Calculate the cost-effectiveness of continuing the coverage under COBRA, if applicable, using the cost of premiums required to obtain continued coverage for the Medicaid-eligible persons in the household.
- Narrate the case record to document the action taken.
- Make sure the local IM worker is aware of this information.

Warrants Returned by the Post Office

When a warrant is returned by the Post Office, there may or may not be an address correction listed on the envelope. In all cases, the IM worker should check the ABC TD01 screen to ascertain whether a new address was reported to the local IM worker.

- If there has been an address change on the ABC system:
  - Print the TD01 screen showing the correct address.
  - Change Payee and Participant screens on HIMM to match the ABC address.
  - Narrate the case record to show "address changed per ABC."
  - Give the warrant to support staff to re-mail to the new address
- If the new address cannot be verified on ABC, e-mail the local IM worker to ask if a new address has been reported.

  If the local IM worker cannot verify an address change, enter the current date as the end date on the Premium Payment Detail Information (HIPPMAP) screen. This will stop further payment from being issued until a valid is obtained. Label the screen, "holding for address verification."

  Attempt to contact the participant by phone or mail, requesting that the participant call to report the new address. If the participant reports the change, it is considered verified. If the new address was not also reported to the local IM worker, e-mail the local IM worker to report the change.

  Re-mail the warrant as indicated above and narrate the progress notes in the case record to document the action taken.

REVIEWS OF ELIGIBILITY

Legal reference: 441 IAC 75.21(11)

The IM worker shall complete a review of HIPP eligibility annually on all HIPP cases. The HIPP system automatically establishes a review date 12 months from the month in which the HIPP file is opened for both employer group plans and for individual plans. The time before the next review may be shortened, but it cannot be lengthened beyond 12 months.

The following sections describe procedures for:

- Reviewing employer group plans
- Reviewing individual policies
- Responding when the participant fails to return review information for a group plan or an individual policy
- Reinstatement reviews

Review of Employer Group Plans

On a monthly basis, the HIPP system generates form 470-3016, *Health Insurance Premium Payment (HIPP) Program Review*, and form 470-3605, *HIPP Review Cover Letter*, for each case due for review.

Support staff mails the review form and cover letter to the participant on each case. The *Health Insurance Premium Payment (HIPP) Program Review* is to be completed by the employer, but the participant is responsible for its timely return.

The IM worker receives a control copy of the review form and the cover letter and receives the *Report of Monthly Reviews* (S474H254-1). This report identifies all reviews due in the following month, as well as current and overdue reviews. See **REPORTS** for more information.

Returned review forms that indicate changes have occurred are priorities and shall be completed first. If the participant does not return the review form, follow the procedures under **Review Form Not Returned**.

For all group plan reviews, the IM worker shall complete the following steps in the review process:

- Ensure that all persons covered by the health plan are reflected on the HIPP system. This includes covered persons who are Medicaid-eligible as well as those who are not. Check the Policyholder/Eligible Cross Reference (TPPFMAP) screen of the HIMM system to verify this has been done.
- Review the ABC TD03 screen and the SSNI screen to confirm that insurance coverage and HIPP participation are coded for each Medicaid-eligible person on the HIPP case. If the coding is not correct, contact the Department's fiscal agent.

- Review and print the ABC TD07 and TD01 screens to check for eligibility changes, addresses changes, etc.
- Enter the data for a new cost-effectiveness determination using any new information provided on form 470-3016, *Health Insurance Premium Payment (HIPP) Program Review*, and current information from the ABC screens.
- If the plan remains cost-effective, enter any new premium information and the current date for review completed on the Premium Detail screen. Update with the **PF04** key.
- Issue a change notice to the participant.
- If there are no reported changes on the review form, mark the appropriate box on the Change Notice screen of the HIMM system.
- Narrate the case record showing that the review was completed and the plan remains cost-effective.

If the plan is no longer cost-effective, complete the review as shown above. Mark the Change Notice Request (HIMMLNR) screen options "REVIEW" and "NO LONGER COST EFFECTIVE." The notice will tell the participant that the review is complete but the initial determination is that the plan is no longer cost-effective and that further determination will be completed.

Then, proceed with the cost-effectiveness evaluation. See **ESTABLISHING COST-EFFECTIVENESS** for more information.

Individual Policies

On a monthly basis, the HIPP system generates form 470-3015, *Insurance Carrier Authorization to Release Information*, and form 470-3017, *HIPP Review Cover Letter*, for the review of individual policies. Support staff mails the letter and the release to the participant.

Returned review forms that indicate changes have occurred are priorities and shall be completed first. If the participant does not return the review form, follow the procedures under **Review Form Not Returned**.

For all individual policy reviews, the IM worker shall complete the following steps in the review process:

- Ensure that all persons covered by the health plan are reflected on the HIPP system. This includes covered persons who are Medicaid-eligible as well as those who are not. Check the Policyholder/Eligible Cross Reference (TPPFMAP) screen of the HIMM system to verify this has been done.
- Review the ABC TD03 screen and the SSNI screen to confirm that insurance coverage and HIPP participation is coded for each Medicaid-eligible person on the HIPP case. If the coding is not correct, contact the Department's fiscal agent.
- Review and print the ABC TD07 and TD01 screens to check for eligibility changes, addresses changes, etc.
- Enter the data for a new cost-effectiveness determination using any new information provided on form 470-3016, *Health Insurance Premium Payment (HIPP) Program Review*, and current information from the ABC screens.
- Send the signed form 470-3015, *Insurance Carrier Authorization to Release Information*, to the insurance company with a cover letter asking for verification of the current premium amount and effective date as well as the current deductible amounts and the dates of any changes. A form letter is available for this purpose.
- If it is determined the case is not cost-effective based on the last known premium and deductible information, also request information regarding the total dollar amount paid in claims in the previous 12 months. Make sure there is a current form 470-2868, *Health Insurance Premium Payment Health History Questionnaire*, (received in the previous 12 months) in the case record.
- Once the request has been mailed to the insurance company, document the progress notes that it has been done and change the review date on the HIMM system.
- Create a tickler on the HIMM system for follow up on the information requested from the insurance company.

Once information is received from the insurance company:

- If premium or deductible information has changed, re-calculate cost-effectiveness.

- Proceed with the required steps for determining cost-effectiveness as shown in **ESTABLISHING COST-EFFECTIVENESS**.
- Issue the applicable review notice.
- Narrate the actions in the case record.

Review Form Not Returned

The review form must be returned to HIPP by the due date listed on the form. If the form is not received in the HIPP Unit by the preprinted due date, cancel the HIPP case with a timely notice for failure to provide requested information.

You may wait a few days beyond the due date to actually send the cancellation notice but in all cases, send the cancellation notice in the time frame that allows a ten-day notice and close the case by the end of the review month.

If the participant is Medicaid-eligible, send form 470-0409, *Medicaid Notice of Sanction*. See **Failure to Cooperate** for more information. File the control copy of the review form in the case record with the *Notice of Cancellation* to document the information that was requested and the date it was due.

Reinstatement Reviews

An abbreviated form of review may be done on a HIPP case when reinstating HIPP benefits following a period of ineligibility for Medicaid.

When reinstating HIPP on a case 30 or more days after it was closed for loss of Medicaid eligibility, you may use the form titled, *Reinstatement Review*. The *Reinstatement Review* is a checklist of the eligibility factors that you must look at before reinstating the HIPP case. It also verifies how the verification was done and when. Use of this form means that the original reason for cancellation (loss of Medicaid eligibility) has now been removed.

If you complete this form and place it in the case record at the time of reinstatement, you may count this as the annual review, changing the date of the annual review on the system to indicate it was done on the current date. Narrate in the case record, "Reinstatement review completed."

OVERPAYMENT AND RECOUPMENT

Legal reference: 441 IAC 76.12(249A)

As a category of service under the Medicaid program, any HIPP payment that was made in error is subject to recoupment. This is true regardless of whether the overpayment was the result of a participant error or an agency error. The Department is responsible for recovering all overpayments of funds incorrectly paid to or on behalf the participant.

If HIPP funds have been paid in error, attempt to recover the overpayment whenever possible through internal adjustment by canceling a returned warrant, crediting a repayment, or offsetting future benefits. Issue a timely and adequate notice to the participant for any adjustment in future payments.

If the overpayment cannot be recovered through any of these means, initiate a referral to the Department of Inspections and Appeals. See **Referral to Department of Inspections and Appeals** for more information.

The following sections describe procedures for:

- Cancelling a warrant
- Crediting a payment
- Offsetting future benefits
- Referring an overpayment to the Department of Inspections and Appeals for collection

Canceling a Warrant

When an original warrant is returned to repay an overpayment, canceling the warrant on the HIPP system voids the payment. To cancel a warrant, the IM worker shall:

- Locate the warrant on the Warrant History Search (HIHSMAP) screen on the HIMM system that is to be canceled. Match the warrant number, issue date, and amount to the corresponding items on the warrant that was returned.
- Select this warrant from the list and open. The Warrant History Information (HIWHMAP) screen will appear.

- Tab down to the CANCEL REA field. On this line, type in the reason for cancellation. There must be an entry in this field for the cancellation action to update. Press the **PF04** key to establish a cancel record. The Warrant History Information (HIWHMAP) screen will now display the message: "WARRANT CANCELED."
- Print the Warrant History Information (HIWHMAP) screen and highlight "WARRANT CANCELED" and the reason that was entered.
- Write "VOID" on the front of the warrant.
- Attach the now canceled warrant to the Warrant History Information screen print and put it in the drawer designated for this purpose. Support staff will send it to Revenue and Finance.
- Keep a copy of the screen print for the case file and narrate the progress notes in the case record.

Crediting a Payment

When the participant, employer or insurance carrier repays a HIPP overpayment with a personal check, money order, cashier's check or other method, the payment is credited to the HIPP warrant that is being repaid.

Upon receipt of a payment that is not the original warrant, the IM worker shall:

- Locate the warrant or warrants to which the credit is to be applied on the Warrant History Search (HIHSMAP) screen on the HIMM system. Every credit must be made to a specific warrant. The system will accept a credit less than or equal to the amount of the warrant to which it is being applied only.
- Select the specific warrant on the Warrant History Search (HIHSMAP) screen. The Warrant History Information (HIWHMAP) screen will appear.
- With the cursor located at the CREDIT AMT field, enter the amount to be credited to the warrant. If the credit amount is greater than the amount of one warrant:
  - Credit the full amount of the warrant to the oldest warrant which contributed to the overpayment; then
  - Credit the balance of the payment to the next warrant or warrants that where part of the overpayment, in chronological order (oldest to newest).

- Next, tab to the field labeled: "CREDIT REA:" A reason for the credit must be entered or the action will not update on the system. Press the **PF03** key for "CREDIT."
- Return to the Warrant History Search (HIHSMAP) screen where the screen will display any credits applied to the specific warrants. Print this screen and attach the payment to it.
- Make a copy of this screen with payment attached to document the case record and narrate the progress notes in the file.
- Place the screen print with payment attached in the drawer designated for this purpose. Support staff will forward it to DHS Payments and Receipts where it will be credited to the HIPP program account.

Offsetting Future Benefits

When the overpaid amount is small, the IM worker may be able to recover the overpayment by offsetting future HIPP benefit payments. When this is done, it is important that the action is narrated in the case record and the appropriate notice is sent to the participant informing them of the action being taken.

On July 12, Mr. H reports that his insurance premium decreased from $50 per month to $45 per month. This change was effective with the July 1 payroll deduction. Mr. H has been overpaid $5 for the July 1 premium.

The HIPP worker reduces the next premium to be issued on July 22 for the August 1 payroll deduction. The HIPP payment will be $40 for August only ($45 minus the $5 overpayment for July). The worker sends a change notice to Mr. H on July 12 notifying him of the change in the ongoing premium reimbursement from $50 to $45 and of the temporary change in the August premium to $40.

Referral to Department of Inspections and Appeals

Legal reference: 441 IAC 76.12(249A)

When an overpayment occurs that cannot feasibly be recovered by an internal adjustment as described above:

- Make a referral to Department of Inspections and Appeals (DIA), using form 470-0464, *Overpayment Recovery Information Input*. Make referrals as soon as possible, but not later than 90 days after the date of the discovery of the overpayment. See 6-G, **Making Referrals to DIA**, for specific instructions on the referral.
- Make two copies of the referral, putting one in the HIPP case record and submitting the other to the HIPP program manager.
- E-mail the participant's local IM worker to report that:
  - You have initiated recoupment on this case;
  - It is a HIPP recoupment; and
  - You are notifying the local worker so the local worker will have the information, should the participant call the local office.

If a warrant or other repayment of part or all of the overpayment is received **after** the referral has been made to DIA, the IM worker shall:

- Follow procedures as shown under **Canceling a Warrant** and **Crediting a Payment**.
- Attach form 470-0010, *Adjustment to Overpayment Balance*, to the screen copy of the canceled warrant or credited payment. Put this documentation with the payment in the front desk drawer to be sent to the Bureau of Purchasing, Payments, and Receipts in the Division of Fiscal Management.

Please note: In rare cases, a Fiscal Management staff member may be unable to post this credit to the Overpayment Recovery System because the case is currently under investigation for fraud or there is a pending appeal.

Should this occur, that staff member will return the payment with this explanation to the HIPP Unit. If the HIPP worker receives a payment with this information, take the following steps:

- Contact the Department of Inspections and Appeals and request direction based on the specific situation. Should they want you to return the payment to the participant, they will provide you with the explanation to give to the participant.
- If the payment is returned, adjust the HIPP system to either "uncancel" the warrant or cancel the credit.

REPORTS

The HIMM system produces various reports to provide information and reminders to workers and to provide statistical resources for the HIPP program. Reports are listed in this section by the staff members responsible for acting on them.

Green-bar and laser reports (e.g. notices of decision) are generated by the Department of Administrative Services' Information Technology Enterprise. Other reports are printed on the network printer in the HIPP Unit.

Reports for Income Maintenance Workers

The following reports are generated for use by income maintenance workers:

- *Active HIPP Cases on Which Medicaid Eligibility Was Lost-Review Cost Effectiveness* (S474H266-1). This report is issued monthly. Review each case listed and recalculate cost-effectiveness. Source: DAS/IT; green-bar report.
- *Active/Pended HIPP Cases With No Coverage Codes* (C474H035-1). This report is generated weekly when a case has been set up but no coverage codes are checked on the system. Correct the coding upon receipt of the report by checking the services that are covered by the health plan. Source: HIPP Unit network.
- *Cost Effectiveness Determination-Buy/Don't Buy* (S474H056-1). This report summarizes the data input by the worker and the result of the system-determined cost-effectiveness calculation. This is the official report required as documentation in the case record. Source: HIPP Unit network printer.

- *Detail Reports of Active/Pended HIPP Cases by Worker Caseload* (C474H805-1). This is the monthly listing of all active cases by worker. This is a useful tool for workers to know for which cases they are responsible. Also, use it periodically to "clean out" closed cases the files. Source: HIPP Unit network printer.

- *Enrollment Expiration Dates Updated per Cancellations* (C474H065-1). This report notifies IM workers that they have issued a cancellation notice on the HIPP case but did not enter an enrollment expiration date to stop payment. The system has automatically updated this date from the cancellation notice. Source: HIPP Unit network printer.

- *HIPP App/Case Found for Referrals Loaded to App Log* (C474H312-1). This report notifies IM workers that there is either another application that could be a duplicate of this referral or there is an active case for this participant. Source: HIPP Unit network printer.

  Support staff attaches this report to the referral and forwards it to the IM worker. Check the application log for possible duplicate applications and the ongoing caseload for an active case when this is indicated. Then process the application appropriately.

- *HIPP Cases Changed to Inactive Status* (S474H058-1). This report is issued daily. Check each case listed as closed to ensure that proper notification has been issued to the participant. Source: DAS/IT; green-bar report.

- *HIPP Cases Changed to Inactive Status - State Only* (S474H058-2). This report is the same as H058-1 but is distributed to the worker responsible for AIDS/HIV HIPP state-only cases. Source: DAS/IT; green-bar report.

- *HIPP Cases With Persons in Medically Needy Aid Types* (S474H282-1). This report is issued monthly. The same cases will appear on this list each month but it is necessary to verify only once on each case. Source: DAS/IT; green-bar report.

  Review each case listed to make sure that the premium is not being used to meet spenddown. Send the local IM worker an e-mail requesting verification that the premium is not being used. Keep this list documenting the local IM worker's response.

- *HIPP Eligibles With Unborn/Newborn Indicator on IABC* (C474H268-1). This report is issued monthly. Source: HIPP Unit network printer.

  Review each HIPP case listed to make sure the pregnancy or newborn on the case is known. Check the case record to make sure the due date has been recorded and the pregnancy letter sent. See **Unborn and Newborn Children** for more information.

- *Persons Becoming TXIX Eligible on State Only Cases* (S474H054-1). This report is generated daily and distributed to the IM worker handling the AIDS/HIV HIPP state only cases. Source: DAS/IT; green-bar report.

- *Persons Changed to TXIX Eligible on HIPP Cases Where Payment Has Ended/Will End* (S474H057-1). This is a daily report that indicates that a HIPP case has been ended (enrollment expiration date present) and that there are individuals on this case who have lost, then regained Medicaid eligibility. Source: DAS/IT; green-bar report.

  Check each case listed to see if a reinstatement is necessary. If reinstatement is indicated, take appropriate action and issue a notice.

- *Policy End Date Report* (S474H262-1). This report is issued monthly. Check each policy on the report to make ensure the end date is known and that proper notification has been issued to the participant. Source: DAS/IT; green-bar report.

- *Recipients With Ins Begin/End Dates Invalid for Policy* (C474H030-1). This is a daily report generated only if an individual is showing insurance coverage dates that fall outside those coverage dates of the policy. Source: HIPP Unit network printer.

  Enter correct dates to fall within the policy begin/end date range. The coverage dates must be accurate when they are passed to the Department's fiscal agent.

- *Report of Monthly Reviews* (S474H254-1). This report is issued monthly by IM worker caseload assignment in conjunction with the automatic issuance of the review forms. The report lists:

  - The reviews that are due in the following month,
  - The reviews that have not yet been completed for the current month, and
  - The reviews that were due before the current month (overdue).

  Upon receipt of this report, give priority to reviews listed as overdue. The review may be listed as overdue in error due to a system problem or failure to code the system when the review was done. Whatever the problem, resolve any issues with overdue reviews first before moving on. Source: DAS/IT; green-bar report.

- *Report of Monthly Reviews-State Only* (S474H254-2). This report is the same as H254-1 but is directed to the IM worker responsible for the AIDS/HIV HIPP state-only cases. Source: DAS/IT; green-bar report.

- *Tickler Report* (S474H066-1). This is a daily report used by all staff members as a reminder of changes that need to be done or followed up. Source: DAS/IT; green-bar report.

Reports for Intake Clerks

The following reports are generated for use by intake workers:

- *Apps In Pended Status 1 Month Prior to Process Month* (C474H231-1). The purpose of this report is to ensure that all applications are acted upon in a timely manner. This report is generated monthly and distributed to the HIPP program manager. The program manager distributes the list to the intake clerks after recording the statistical facts.

  The report is organized by the alphabetical breakdown for each intake clerk. It displays portions of the application log that indicate what has been done or needs to be done on the application.

  This report includes data for all applications shown as pending in the month before the process month. For example, for the report received in May, April is the process month, so the report displays all applications that were pended in March.

  Use this report to manage any outstanding applications on which action is needed. Source: DAS/IT; green-bar report.

- *Apps In Pended Status After: (Month), (Year)* (C474H231-2). This report is generated monthly and distributed to the HIPP program manager. The program manager records the statistics from this report and then distributes it to the intake clerks for resolution of pending applications.

  The report is organized by the alphabetical breakdown for each intake clerk. It displays portions of the application log that indicate what has been done or needs to be done on the application.

  This report differs from report C474H231-1 in that it is a more comprehensive list. This list displays all applications that were in pending status (not having been denied, approved, or sanctioned) as of the date of the report and were pended or had a future enrollment date after a pre-determined beginning date (currently May 2003).

  The list displays all applications pended beginning with this period and ending two months before the process month. For example, a report dated June 2004 lists all applications pended (or with a future enrollment date) in the period after May 2003 and ending with those pended in March 2004. (The process month is May and March is two months prior).

Pended applications displayed on report C474H231-1 are not included on this list. Source: DAS/IT – green-bar report.

- *Cost Effectiveness Determination-Buy/Don't Buy* (S474H056-1). This report summarizes the data input by the worker and the result of the system-determined cost-effectiveness calculation. This is the official report required as documentation in the case record. Source: HIPP Unit network printer.
- *HIPP Future Enrollment Report* (S474H286-A). This report is generated monthly, in the month before the month in which the application is subject to future enrollment. Locate applications on the list, print current ABC screens, and distribute the report to IM workers by alphabetical breakdown. Source: DAS/IT; green-bar report.
- *Tickler Report* (S474H066-1). This is a daily report used by all staff members as a reminder of changes that need to be done or followed up. Source: DAS/IT; green-bar report.

Reports for Support Staff

The following reports are generated for use by support staff:

- *Daily Warrant Report* (S474H055-1). This report lists all warrants issued by the HIMM system. A *Daily Warrant Report* is also distributed to the mail contractor with the daily warrants. Source: DAS/IT; green-bar report.

  Hold this report until the *Purchase Order/Payment Voucher*, form 07-350, is received from the mail contractor. Match the two documents and staple them together. Hold these reports for a period of three months, and then destroy them.

- *Purchase Order/Payment Voucher* (07-350). This report contains daily certification totals. Two copies of this report are generated. One copy is sent to the support staff as a control copy and one is sent to the mail contractor for match up with the *Daily Warrant Report*. Source: Division of Fiscal Management I/3 system laser printer.

  Save the control copy until the original report is received from the mail contractor. It should be signed and dated with the date the warrants are mailed. Attach this to the corresponding *Daily Warrant Report* and retain both for three months for reference. Destroy the control copy of this form when you receive the signed copy from the mail contractor.

- *HIPP App/Case Found for Employment End Dates* (C474H316-1). This report is created from the HIRF referrals. When local IM workers report employment end dates via the HIRF referral process, the system matches the referral with the HIPP application log and active HIPP cases to identify any employer matches. Source: DAS/IT; green-bar report.

  Look up potential matches identified on the report to determine if they are actual matches. Refer any potential matches to the IM worker responsible for the case for resolution.

Reports for Program Manager

The following reports are generated for use by the HIPP program manager:

- *Active/Pended HIPP Case Counts by Alphabet* (S474H245-1). This report is generated monthly. File for reference. Source: HIPP Unit network printer.
- *Active/Pended HIPP Case Counts by Caseload* (S474H245-2). This report is generated monthly. Record on the spreadsheet entitled "Number of Active Cases" (caseload). File for reference. Source: HIPP Unit network printer.
- *Active Policyholders With COBRA* (S474H243). This report is generated monthly. File for reference. Source: HIPP Unit network printer.
- *AIDS/HIV Cases* (S474H258-2). This is a monthly report of the number of state-only participants. File for reference. Source: HIPP Unit network printer.
- *Apps In Pended Status One Month Prior to Process Month* (C474H231-1). This report is generated monthly. File for reference. Source: DAS/IT; green-bar report.
- *Apps In Pended Status After (Month), (Year)* (C474H231-3). This report is generated monthly. File for reference. Source: HIPP Unit network printer.
- *Average Premium Payment for Active Policyholders* (S474H233-1). This report is generated monthly. File for reference. Source: HIPP Unit report from network printer.
- *Count of Applications by County* (S474H287). This report is generated monthly. Update the spreadsheet entitled "Apps by County" and file for reference. Source: HIPP Unit network printer.
- *Counts of HIPP Customers* (S474H247-1). This report is generated monthly. Update the spreadsheet and file for reference. Source: HIPP Unit network printer.

- *HIPP Application Monthly Activity Report-Pended Totals* (S474H297-1). This report is generated monthly and records the number of pended applications by clerk. File for reference. Source: HIPP Unit network printer.
- *HIPP Application Monthly Activity Report-Denied/Sanctioned Totals* (S474H298-1). This report is generated monthly and records the number of denials and sanctions by clerk. Update the spreadsheet entitled "Monthly Activity Report" and file for reference. Source: HIPP Unit network printer.
- *HIPP Cases* (C474H805-1). This report is generated and distributed monthly to the IM worker and is printed as needed for the program manager for caseload adjustment.
- *HIPP Cost History Report* (S474H450-1). This report is generated annually after the new cost-effective figures are implemented in July. File this written report for reference. Source: DAS/IT laser printer.
- *HIPP Employers Added* (C474H620-1). This report is generated monthly. Update the spreadsheet entitled "Employer Insurance Files Added" and e-mail a copy of the spreadsheet to the intake clerks. Source: HIPP Unit network printer.
- *HIPP Enrollment Tax ID's Not Found on I/3* (C474H059-1). This report is a safeguard to make sure warrants go out when the I/3 system changes or deletes an employer tax ID number. It is generated sporadically as needed. Work with the IM worker to correct the issuance. Source: HIPP Unit network printer.
- *Monthly Activity Report* (S474H284-A). This report is generated monthly and measures the work activity of the intake clerks, both by assigned parts of the alphabet and by who actually does the work. Record the data on the appropriate spreadsheet and file the report for reference. Source: HIPP Unit network printer.
- *Persons Receiving HIPP Coverage Total Page Only* (S474H258-1). This report is generated monthly and records the number of eligibles and non-eligibles served by the program. Update the spreadsheet entitled "Eligibles" and save the report for reference. Source: HIPP Unit network printer.
- *Persons Receiving HIPP Coverage-State Only-Total Page Only* (S474H258-2). This report is generated monthly. Update the spreadsheet and file the report for reference. Source: HIPP Unit network printer.
- *Report of Monthly Reviews* (S474H254-1). This report is generated monthly. Update the spreadsheet entitled "Reviews" and e-mail a copy of the spreadsheet to IM workers. File for reference. Source: DAS/IT; green-bar report.

- *Report of Monthly Reviews-State Only* (S474H254-2). This report is generated monthly. File for reference. Source: DAS/IT; green-bar report.
- *Warrant Report* (S474H256-1). This is a report of all warrants issued in the previous month. It is issued monthly. File for reference. Source: DAS/IT; green-bar report.
- *Warrants of $1,000.00 or More* (S474H049-1). This is a report created for auditing purposes. It is issued daily. Check each name with the system to determine if the issuance looks valid and correct. Monitor the case record if questionable. Source: DAS/IT; green-bar report.

Fields of Opportunities

STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

November 19, 2004

GENERAL LETTER NO. 5-B-62

ISSUED BY: Bureau of Health Insurance
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 5, Chapter B, ***HEALTH INSURANCE PREMIUM PAYMENT PROGRAM***, Title page, new; Contents (pages 1, 2, and 3), new; and pages 1 through 72, new.

Summary

This chapter contains worker instructions for the administration of the Health Insurance Premium Payment (HIPP) Program. Parts of the material were formerly included in Chapter VIII-G(1).

Effective Date

Upon receipt.

Material Superseded

None.

Additional Information

Refer questions about this general letter to your area income maintenance supervisor 2.