441—75.21(249A) Health insurance premium payment program. Under the health insurance premium payment program, the department shall pay for the cost of premiums, coinsurance and deductibles for Medicaid-eligible individuals when the department determines that those costs will be less than the cost of paying for the individual's care directly.

75.21(1) *Condition of eligibility.* The recipient, or a person acting on the recipient's behalf, shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of group health insurance. Persons who are eligible to enroll in a group health insurance plan which the department has determined is cost-effective, and who are otherwise eligible for Medicaid, shall apply for enrollment in the plan as a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid-eligible persons through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

When a parent fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

a. There was a serious illness or death of the parent or a member of the parent's family.

b. There was a family emergency or household disaster, such as a fire, flood, or tornado.

c. The parent offers a good cause beyond the parent's control.

d. There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the 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.

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

75.21(2) *Non-employer related health insurance plans.* Participation in a health insurance plan that is not group health insurance as defined in rule 441—75.25(249A) is not a condition of Medicaid eligibility.

75.21(3) *Cost-effectiveness.* Cost-effectiveness shall mean the expenditures in Medicaid payments for a set of services are likely to be greater than the cost of paying the premiums and cost-sharing obligations under an insurance plan for those services. When determining the cost-effectiveness of the insurance plan, the following data shall be considered:

a. The cost of the insurance premium, coinsurance and deductibles. An employer-related group health insurance plan that provides major medical coverage and costs $50 or less per month shall be determined cost-effective when establishing eligibility for one-person Medicaid-eligible households. An employer-related group health insurance plan that provides major medical coverage and costs $100 or less per month shall be determined cost-effective when establishing eligibility for households of two or more Medicaid-eligible persons.

b. The scope of services covered under the insurance plan, including exclusions for preexisting conditions, etc.

c. The average anticipated Medicaid utilization, by age, sex, institutional status, Medicare eligibility, and coverage group, for persons covered under the insurance plan.

d. The specific health-related circumstances of the persons covered under the insurance plan. The HIPP Medical History Questionnaire, Form 470-2868, shall be used to obtain this information. Employer-related group health insurance plans that provide major medical coverage shall be determined cost-effective when there is a Medicaid-eligible pregnant woman who can be covered under the plan.

e. Annual administrative expenditures of $50 per Medicaid recipient covered under the health insurance policy.

f. Whether the estimated savings to Medicaid for persons covered under the health insurance plan are at least $5 per month per household.

75.21(4) *Coverage of non-Medicaid-eligible family members.* When it is determined to be cost-effective, the department shall pay for health insurance premiums for non-Medicaid-eligible family members if a non-Medicaid-eligible family member must be enrolled in the health plan in order to obtain coverage for the Medicaid-eligible family members. However, the needs of the non-Medicaid-eligible family members shall not be taken into consideration when determining cost-effectiveness and payments for deductibles, coinsurances or other cost-sharing obligations shall not be made on behalf of family members who are not Medicaid-eligible.

75.21(5) *Exceptions to payment.* Premiums shall not be paid for health insurance plans under any of the following circumstances:

a. The insurance plan is that of an absent parent.

b. The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (e.g., $50 per day for hospital services instead of 80 percent of the charge).

c. The insurance plan is a school plan offered on basis of attendance or enrollment at the school.

d. The premium is used to meet a spenddown obligation under the medically needy program, as provided in subrule 75.1(35), when all persons in the household are eligible or potentially eligible only under the medically needy program. When some of the household members are eligible for full Medicaid benefits under coverage groups other than medically needy, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full Medicaid coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the medically needy program.

e. The insurance plan is designed to provide coverage only for a temporary period of time (e.g., 30 to 180 days).

f. The persons covered under the plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made.

g. The person is eligible only for limited Medicaid services under the specified low-income Medicare beneficiary (SLMB) coverage group, in accordance with subrule 75.1(34).

h. Insurance coverage is being provided through the Iowa Comprehensive Health Insurance Association, in accordance with Iowa Code chapter 514E.

i. Insurance is being maintained on the Medicaid-eligible persons in the household through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

j. The insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

75.21(6) *Duplicate policies.* When more than one cost-effective health insurance plan or policy is available, the department shall pay the premium for only one plan. The recipient may choose in which cost-effective plan to enroll. However, in situations where the department is buying in to the cost of Medicare Part A or Part B for eligible Medicare beneficiaries, the cost of premiums for a Medicare supplemental insurance policy may also be paid if the department determines it is likely to be cost-effective to do so.

75.21(7) *Discontinuation of premium payments.*

a. When the household loses Medicaid eligibility, premium payments shall be discontinued as of the month of Medicaid ineligibility.

b. When only part of the household loses Medicaid eligibility, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective. If it is determined the policy is no longer cost-effective, premium payment shall be discontinued pending timely and adequate notice.

c. If the household fails to cooperate in providing information necessary to establish ongoing eligibility, the department shall discontinue premium payment after timely and adequate notice. The department shall request all information in writing and allow the policyholder ten calendar days in which to provide it.

d. If the policyholder leaves the household, premium payments shall be discontinued pending timely and adequate notice.

e. If the insurance coverage is no longer available or the policy has lapsed, premium payments shall be discontinued as of the effective date of the termination of the coverage.

75.21(8) *Effective date of premium payment.* The effective date of premium payments for cost-effective health insurance plans shall be determined as follows:

a. Premium payments shall begin no earlier than the first day of the month in which the Employer's Statement of Earnings, Form 470-2844, or the Health Insurance Premium Payment Application, Form 470-2875, is received by the division of medical services or the first day of the first month in which the plan is determined to be cost-effective, whichever is later.

b. If the person is not enrolled in the plan when eligibility for participation in the HIPP program is established, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs.

c. If there was a lapse in coverage during the application process (e.g., the policy is dropped and reenrollment occurs at a later date), premium payments shall not be made for any period of time prior to the current effective date of coverage.

d. In no case shall payments be made for premiums which were used as a deduction to income when determining client participation, the amount of the spenddown obligation, or for premiums due for periods of time covered prior to July 1, 1991.

The Employer Verification of Insurance Coverage, Form 470-3036, shall be used to verify the effective date of coverage and premiums for persons enrolled in group health insurance plans.

75.21(9) *Method of premium payment.* Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

a. The department may arrange for payment to the employer in order to circumvent a payroll deduction.

b. When the employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall reimburse the policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums. The department shall issue reimbursement to the policyholder five working days prior to the policyholder's pay date.

c. When premium payments are occurring through an automatic withdrawal from a bank account by the insurance carrier, the department may reimburse the policyholder for said withdrawals.

d. When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall reimburse the policyholder for premium payments made to the entity.

75.21(10) *Payment of claims.* Claims from medical providers for persons participating in this program shall be paid in the same manner as claims are paid for other persons with a third-party resource in accordance with the provisions of 441—Chapters 79 and 80.

75.21(11) *Reviews of cost-effectiveness.* Reviews of cost-effectiveness shall be completed annually or at the time of the next health insurance contract renewal date for employer-related group health plans. Reviews may be conducted more frequently at the discretion of the department. The Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, shall be used for this purpose.

Reviews of cost-effectiveness shall be completed annually for non-employer-related group health plans. The recipient shall sign the Insurance Carrier Authorization to Release Information, Form 470-3015, as part of the review of non-employer-related plans so that the department may obtain pertinent information necessary to establish continued eligibility.

Failure of the policyholder to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

Redeterminations shall also be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full Medicaid eligibility, employment terminates or hours are reduced which affects the availability of health insurance, the

insurance carrier changes, the policyholder leaves the home, or there is a decrease in the services covered under the policy. The policyholder shall report changes that may 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. A HIPP Change Report, Form 470-3007, shall accompany all premium payments.

When employment terminates, hours of employment are reduced, or some other qualifying event affecting the availability of health insurance coverage occurs, the department 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 other insurance continuation provisions. The Employer Verification of COBRA Eligibility, Form 470-3037, shall be used for this purpose. If cost-effective, the department shall pay premiums to maintain insurance coverage for eligible Medicaid recipients after the occurrence of the qualifying event which would otherwise result in termination of coverage.

75.21(12) *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the insurance plan and notify the recipient of the decision regarding payment of the premiums within 65 days from the date an Employer's Statement of Earnings, Form 470-2844, indicating the availability of group insurance or a Health Insurance Premium Payment Application, Form 470-2875, is received. Additional time may be granted when, for reasons beyond the control of the department or the recipient, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.

75.21(13) *Notices.* An adequate notice shall be provided to the household under the following circumstances:

a. To inform the household of the initial decision on cost-effectiveness and premium payment.

b. To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy.

c. The policy is no longer available to the family (e.g., the employer drops insurance coverage or the policy is terminated by the insurance company).

The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective or because the recipient has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *Rate refund.* The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due for any time period for which the department paid the premium.

75.21(15) *Reinstatement of eligibility.*

a. When eligibility for the HIPP program is canceled because the persons covered under the policy lose Medicaid eligibility, HIPP eligibility shall be reinstated when Medicaid eligibility is reestablished if all other eligibility factors are met.

b. When HIPP eligibility is canceled because of the recipient's failure to cooperate in providing information necessary to establish continued eligibility for the HIPP program, benefits shall be reinstated the first day of the first month in which cooperation occurs.

This rule is intended to implement Iowa Code section 249A.3.