

**HUMAN SERVICES DEPARTMENT[441]**

**Notice of Intended Action**

**Proposing rule making related to HIPP program eligibility  
and providing an opportunity for public comment**

The Human Services Department hereby proposes to amend Chapter 75, “Conditions of Eligibility,” Iowa Administrative Code.

*Legal Authority for Rule Making*

This rule making is proposed under the authority provided in Iowa Code section 249A.4.

*State or Federal Law Implemented*

This rule making implements, in whole or in part, Iowa Code section 249A.4.

*Purpose and Summary*

The proposed amendments change the start date for Health Insurance Premium Payment (HIPP) Program approval for fee-for-service and premium assistance. The earliest start date for fee-for-service and premium assistance will be the first day of the month following the month of application. The proposed amendments also change the estimated savings to the Department per household from \$60 annually to \$1,200 annually and eliminate the second cost-effective test. Finally, the proposed amendments provide technical changes to policy and definitions.

*Fiscal Impact*

This rule making has a fiscal impact to the State of Iowa of less than \$100,000 annually or \$500,000 over five years. These changes would reduce the number of Medicaid members who qualify for the HIPP program, move members with relatively small savings

into managed care, streamline the program, and minimize administrative burden/cost.

Change in effective date: Currently, the effective date of an approved HIPP application is the first day of the month the application was received. The change would result in an effective date of no earlier than the first day of the month following the month of application. This change would eliminate, including but not limited to, the need to extract a member from managed care organization (MCO) assignment (including dental), recover MCO capitation fees, and retroactively reassign individualized services information system (ISIS) dates and case managers.

Change to the estimated savings: This change would require a higher household savings threshold in order for an application or case to be cost-effective for the program. Approved applications would be reduced by approximately 30 cases per year. An estimated 175 active cases (263 members) would gradually lose HIPP eligibility due to no longer being cost-effective.

Elimination of the second cost-effective test: Currently, if a HIPP case is not cost-effective based on the cost-effectiveness tool, staff request paid insurance claims from the past 12 months. If the value of the claims paid by the insurance company is more than the cost of the insurance premiums, deductible, and administrative cost, and saves the state at least \$60, this second test overrides the average cost-effectiveness calculation. As a result of eliminating this second test and relying only on the cost-effectiveness tool, it is estimated approximately 140 cases (210 members) would no longer qualify for the program. These cases would gradually lose HIPP eligibility due to no longer being cost-effective.

Technical changes: The purpose of these technical changes is for the HIPP program

to avoid paying for insurance plans that do not have the potential to save the state money. It is estimated that fewer than ten members will be impacted by this change.

*Jobs Impact*

After analysis and review of this rule making, no impact on jobs has been found.

*Waivers*

A waiver is not needed as part of this statute. HIPP policy needs a state plan amendment (SPA) approval and third party liability (TPL) action plan approval from the U.S. Centers for Medicare and Medicaid Services (CMS).

*Public Comment*

Any interested person may submit written comments concerning this proposed rule making. Written comments in response to this rule making must be received by the Department no later than 4:30 p.m. on April 16, 2019. Comments should be directed to:

Harry Rossander  
Bureau of Policy Coordination  
Department of Human Services  
Hoover State Office Building, Fifth Floor  
1305 East Walnut Street  
Des Moines, Iowa 50319-0114  
Email: [policyanalysis@dhs.state.ia.us](mailto:policyanalysis@dhs.state.ia.us)

*Public Hearing*

No public hearing is scheduled at this time. As provided in Iowa Code section 17A.4(1)“b,” an oral presentation regarding this rule making may be demanded by 25

interested persons, a governmental subdivision, the Administrative Rules Review Committee, an agency, or an association having 25 or more members.

*Review by Administrative Rules Review Committee*

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions are proposed:

ITEM 1. Amend subrule **75.21(1)**, definitions of “Cost-effective,” “High-deductible health plan” and “HIPP-eligible member,” as follows:

“*Cost-effective*” means a determination has been made ~~that a savings will accrue to the department by paying the insurance premium, cost sharing, wrap benefits, and administrative cost~~ that the amount the department would pay for the member's insurance premiums, cost sharing, wrap benefits, and administrative costs is likely to be less than the amount the department would pay through Medicaid, including managed care capitation fees, for the member. Cost-effectiveness is determined pursuant to subrule 75.21(3).

“*High-deductible health plan*” ~~or “HDHP”~~ means a health insurance plan that meets the definition found in Section 223(c)(2) of the Internal Revenue Code.

“*HIPP-eligible member*” means a ~~person whose Medicaid eligibility is calculated in the cost-effective determination for HIPP. “HIPP-eligible member” is also referred to as HIPP-enrollee~~ member who has been determined eligible pursuant to subrule 75.21(3) and is used in the cost-effective test to determine eligibility for the HIPP program.

ITEM 2. Adopt the following **new** definitions of “Effective date of approval” and “HIPP household” in subrule **75.21(1)**:

*“Effective date of approval”* means the HIPP start date for premium payments and eligibility for an application on which all the requested documentation and information has been provided and which has been found to be cost-effective pursuant to this rule. Unless otherwise stated within this rule, the effective date of approval shall be no earlier than the first day of the month following the month of application. For applications approved on or after the 15th calendar day of the month, the effective date of approval shall be no earlier than the first day of the month following the month following the application approval date.

*“HIPP household”* means at least one member is a participant in the HIPP program.

ITEM 3. Rescind the definition of “Employer-sponsored insurance” in subrule **75.21(1)**.

ITEM 4. Amend paragraph **75.21(2)“b”** as follows:

*b.* The insurance plan is cost-effective ~~as defined in~~ pursuant to subrule 75.21(3).

ITEM 5. Rescind paragraph **75.21(3)“d”** and adopt the following **new** paragraph in lieu thereof:

*d.* Annual administrative expenditures of \$150 per HIPP member covered under the health plan.

ITEM 6. Amend paragraph **75.21(3)“e”** as follows:

*e.* Annual ~~administrative expenditures~~ savings of \$150 \$1,200 per HIPP ~~member~~ covered under the health plan household.

ITEM 7. Rescind paragraph **75.21(3)“f.”**

ITEM 8. Amend paragraph **75.21(5)“d”** as follows:

*d.* The insurance premium is used to meet a spenddown obligation under the medically needy program, ~~as provided in~~ pursuant to 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 insurance 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.

ITEM 9. Amend paragraph **75.21(5)“f”** as follows:

*f.* The persons covered under the insurance plan are not Medicaid-eligible on the date the decision regarding eligibility for the HIPP program is made. No retroactive payments shall be made if the ~~case~~ member is not Medicaid-eligible on the date of decision.

ITEM 10. Amend paragraph **75.21(5)“r”** as follows:

*r.* The insurance plan is ~~an HDHP~~ a high-deductible health plan.

ITEM 11. Adopt the following **new** paragraph **75.21(5)“s”**:

*s.* There is no cost to the policyholder to cover the Medicaid-eligible member on the insurance plan.

ITEM 12. Adopt the following **new** paragraph **75.21(5)“t”**:

*t.* The insurance plan provider panel does not have an in-network presence in the

state of Iowa.

ITEM 13. Adopt the following **new** paragraph **75.21(5)“u”**:

*u.* The insurance plan is not compliant with the Affordable Care Act, 42 U.S.C.

Chapter 157.

ITEM 14. Adopt the following **new** paragraph **75.21(5)“v”**:

*v.* The member is a medically needy participant, pursuant to subrule 75.1(35).

ITEM 15. Adopt the following **new** paragraph **75.21(5)“w”**:

*w.* The member is a participant in Medicaid for working persons with disabilities, pursuant to subrule 75.1(39).

ITEM 16. Rescind subrule 75.21(6) and adopt the following **new** subrule in lieu thereof:

**75.21(6)** *Department evaluation and verification of insurance plans.* Only plans in which a member is actively enrolled shall be evaluated.

*a.* For employer-sponsored insurance plans, Form 470-3036, Employer Verification of Insurance Coverage, shall be used to verify the effective date of coverage and costs for persons enrolled in group health plans through an employer.

*b.* For individual plans, the effective date of coverage shall be verified by a certificate of coverage for the plan or by some other verification from the insurer.

ITEM 17. Rescind subrule 75.21(7) and adopt the following **new** subrule in lieu thereof:

**75.21(7)** *Exceptions to the effective date of approval or premium payment.* The effective date of approval shall be as defined in subrule 75.21(1) unless the department requests in writing to add a member to an available insurance plan. In such event, the

member's effective date of approval shall be the first of the month in which the first premium payment is due.

ITEM 18. Amend paragraph **75.21(10)“a”** as follows:

a. Annual review of ESI employer-sponsored insurance plan cost-effectiveness and eligibility shall be completed using Form 470-3016, Health Insurance Premium Payment (HIPP) Program Review.

ITEM 19. Amend paragraph **75.21(10)“d”** as follows:

d. Redeterminations of cost-effectiveness shall be completed whenever:

(1) to (7) No change.

ITEM 20. Amend paragraph **75.21(10)“e”** as follows:

e. The ~~policyholder~~ member or the member's authorized representative shall report changes that may affect the availability of the insurance plan reimbursed by the HIPP program, or changes that affect the cost-effectiveness of the policy, within ten calendar days from the date of the change.

ITEM 21. Amend subrule 75.21(11) as follows:

**75.21(11)** *Time frames for determining cost-effectiveness.* The department shall determine cost-effectiveness of the insurance plan and notify the applicant of the decision regarding payment of the premiums within 65 calendar days from the date an application or referral (as defined in subrule ~~75.21(7)~~ 75.21(1)) is received. ~~Additional time may be taken when, for reasons beyond the control of the department or the applicant, information needed to establish cost-effectiveness cannot be obtained within the 65-day period.~~

ITEM 22. Amend paragraph **75.21(12)“b”** as follows:

b. The department shall provide timely and adequate notice ~~as defined in~~ pursuant

to 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) and (2) No change.

ITEM 23. Amend paragraph **75.21(15)“a”** as follows:

*a.* For ~~ESI~~ employer-sponsored insurance plans, the policyholder shall provide verification of the cost of all possible insurance plan options (i.e., single, employee/children, family).

(1) and (2) No change.



Iowa Department of Human Services  
**Information on Proposed Rules**

Name of Program Specialist Ann Bagley	Telephone Number 515-974-3272	Email Address abagley@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

- Change the start date for HIPP approval for fee-for-service and premium assistance.  
The earliest start date for fee-for-service and premium assistance is the first day of the month following the month of application.
- Change the estimated savings to the Department from \$60 annually to \$1200 annually.
- Eliminate the second cost-effective test.
- Technical changes to policy and definitions listed below are excluded for reimbursement or edibility from the HIPP program:
  - Plans that are at no cost to the policyholder to cover the Medicaid-eligible.
  - Plans that do not have an in-network provider panel in the State of Iowa.
  - Insurance plan is not compliant with the Affordable Care Act, 42 U.S.C. Ch. 157.
  - The member is a Medically Needy participant, pursuant to subrule 441-75.1(35).
  - The member is a participant on Medicaid for Working Persons with Disabilities, pursuant to subrule 441-75.1(39)

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

249A.4

3. Describe who this rulemaking will positively or adversely impact.

- The change in the effective date is to discontinue the current practice of extracting members from an MCO when approved for the HIPP program to prevent turning of claims and case management.
- The change to save \$1200 per year is to increase the savings to the program.
- Elimination of the second cost-effective test is requested because comparing what the insurance plan paid out to the cost of what the HIPP program pays is no longer relevant due to the inception of managed care.
- The change to exclude from HIPP reimbursement plans that are available at no cost, do not have Iowa providers, do not meet the ACA requirements, and when the member is on Medically Needy or Medicaid for Working Persons with Disabilities, is to avoid paying for insurance plans that have the potential not to save the state money.

4. Does this rule contain a waiver provision? If not, why?

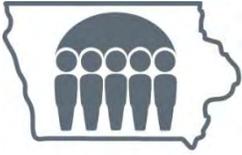
A waiver is not needed as part of this statute. HIPP policy needs a state plan amendment (SPA) approval and Third Party Liability (TPL) Action plan approval from CMS.

5.What are the likely areas of public comment?

New members who are eligible for HIPP reimbursement will not be retroactively reimbursed back to the date of application for their insurance premiums. Some members who may be eligible for the HIPP program now will no longer be eligible for the HIPP program due to the higher dollar requirement for savings and the elimination of the second cost-effective test. Members who are active on HIPP who are cost-effective based on claims will not be please to no longer be HIPP eligible. The new exclusions to the type of policies allowed for reimbursement may effective some.

6.Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

No



## Administrative Rule Fiscal Impact Statement

Date: December 18, 2018

**Agency:** Human Services

**IAC citation:** 441 IAC 75.21

**Agency contact:** Ann Bagley

### Summary of the rule:

Change the start date for HIPP approval for fee-for-service and premium assistance. The earliest start date for fee-for-service and premium assistance is the first day of the month following the month of application.

Change the estimated savings to the Department from \$60 annually to \$1200 annually.

Eliminate the second cost-effective test.

Technical changes to policy and definitions listed below are excluded for reimbursement or eligibility from the HIPP program:

- o Plans that are at no cost to the policyholder to cover the Medicaid-eligible.
- o Plans that do not have an in-network provider panel in the State of Iowa.
- o Insurance plan is not compliant with the Affordable Care Act, 42 U.S.C. Ch. 157.
- o The member is a Medically Needy participant, pursuant to subrule 441-75.1(35).
- o The member is a participant on Medicaid for Working Persons with Disabilities, pursuant to subrule 441-75.1(39)

*Fill in this box if the impact meets these criteria:*

- No fiscal impact to the state.
- Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
- Fiscal impact cannot be determined.

### Brief explanation:

These changes will reduce the number of Medicaid members qualifying for the HIPP program. The changes will move members with relatively small savings into managed care. It will also streamline the program and minimize administrative burden/cost.

Change in effective date:

The current process is the effective date of an approved application is the first day of the month the application was received. The change will result in an effective date no earlier than the first day of the month following the month of application. This change will eliminate the need to extract a member from MCO assignment (including dental), recover MCO capitations fees, retroactively reassign ISIS dates and case managers, etc.

Change to the estimated savings:.

This change would require a higher savings threshold in order for an application or case to be cost-effective for the program. Approved applications would be reduced by approximately 30 cases per year. An estimated 175 active cases (263 members) would gradually lose HIPP eligibility due to no longer being cost-effective.

Elimination of the second cost-effective test:

Currently, if a HIPP case is not cost-effective based on the cost-effectiveness tool, staff request paid

insurance claims from the past 12 months. If the value of the claims paid by the insurance company are more than the cost of the insurance premiums, deductible, administrative cost, and saves the state at least \$60, this second test overrides the average cost-effectiveness calculation. As a result of eliminating this second test and relying only on the cost-effectiveness tool it is estimated approximately 140 cases (210 members) will no longer qualify for the program. These cases would gradually lose HIPP eligibility due to no longer being cost-effective.

**Technical changes:**

The purpose of these technical changes is to avoid paying for insurance plans that have the potential to not save the state money. It is estimated that fewer than ten members will be impacted by this change.

*Fill in the form below if the impact does not fit the criteria above:*

Fiscal impact of \$100,000 annually or \$500,000 over 5 years.

***Assumptions:***

***Describe how estimates were derived:***

**Estimated Impact to the State by Fiscal Year**

	<u>Year 1 (FY 2020)</u>	<u>Year 2 (FY 2021)</u>
<b>Revenue by each source:</b>		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
<b>TOTAL REVENUE</b>	_____	_____
<b>Expenditures:</b>		
General fund	_____	_____
Federal funds	_____	_____
Other (specify):	_____	_____
<b>TOTAL EXPENDITURES</b>	_____	_____
<b>NET IMPACT</b>	_____	_____

This rule is required by state law or federal mandate.  
*Please identify the state or federal law:*  
 Identify provided change fiscal persons:

Funding has been provided for the rule change.  
*Please identify the amount provided and the funding source:*

Funding has not been provided for the rule.  
*Please explain how the agency will pay for the rule change:*  
 The changes will be covered by existing appropriations.

***Fiscal impact to persons affected by the rule:***  
 New members who are eligible for HIPP reimbursement will not be retroactively reimbursed back to the date of application for their insurance premiums. Some members who may be eligible for the HIPP program now will no longer be eligible for the HIPP program due to the higher dollar requirement for savings and the elimination of the second cost-effective test. The new exclusions to the type of policies allowed for reimbursement may also affect a small number of members,

***Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):***  
 No fiscal impact anticipated.

Agency representative preparing estimate: Jason Buls  
 Telephone number: 515-281-5764