State/Territory: California

State Methodology for Determining Cost-Effectiveness of Individual and Group Health Plans

The Health Insurance Premium Payment (HIPP) program is a voluntary program for qualified beneficiaries with full scope Medi-Cal coverage. HIPP approved Medi-Cal eligible beneficiaries shall receive services that are unavailable from third party coverage and offered by Medi-Cal. Beneficiaries with restricted Medi-Cal coverage are not eligible for the HIPP program.

The methodology used by California for determining cost-effectiveness of paying individual or group health insurance premiums for existing coverage shall be as follows:

A. Any Medi-Cal beneficiary who has an existing, medically confirmed medical condition determined by the Department of Health Care Services (DHCS) to be a cost-effective condition is deemed to meet the cost-effectiveness criteria for the HIPP program.

If A is not applicable, then the following will be used to determine cost-effectiveness:

B. Cost-Effectiveness Methodology:
   (1) Enrollment in an individual or group health insurance plan shall be considered cost-effective when the cost of paying premiums, coinsurance, deductibles, other cost-sharing obligations, and administrative costs are projected to be less than the amount paid for an equivalent set of Medi-Cal services.
      a. The confirmed medical condition must be covered under the individual or group health insurance plan upon date of application.
   (2) When determining cost-effectiveness of individual or group health insurance plans, DHCS shall consider the following information:
      a. The cost of the insurance premium, coinsurance, deductible;
      b. The average yearly anticipated Medi-Cal utilization for the confirmed medical condition;
      c. The specific health-related circumstances of the persons covered under the insurance plan; and
      d. Annual administrative expenditures.
   (3) In any month that a HIPP enrollee has not met his/her monthly spend-down obligation, the enrollee will not be reimbursed.
   (4) In order to meet the cost-effectiveness criteria, HIPP enrollees are required to be in fee-for-service (FFS) Medi-Cal.

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C. Redetermination Review
(1) DHCS shall complete a redetermination review at least yearly for all HIPP enrollees. The yearly review shall consist of:
   a. Verifying Medi-Cal eligibility;
   b. Completing a cost-effective analysis under A and/or B.
(2) If determined to be cost-effective under A or B, then DHCS may re-determine eligibility at any point if:
   a. A predetermined premium rate, deductible, or coinsurance increase is greater than or equal to $100;
   b. There is a:
      i. Change in Medi-Cal eligibility;
      ii. Or a decrease in the services covered under the policy.
(3) Failure to submit required documents for redetermination may result in disenrollment from the HIPP program.
(4) Failure to meet HIPP enrollment eligibility during redetermination, under A or B, will result in disenrollment.

D. Coverage of Non-Medi-Cal Family Members
(1) The HIPP program shall pay the premiums for additional family members who are not Medi-Cal eligible, if the individual’s premium amount cannot be separated from the family premium amount. The needs of other family members shall not be taken into consideration when determining cost-effectiveness of a group health insurance plan.
(2) DHCS shall not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of non-HIPP enrollees.

E. Purchasing or paying for health insurance coverage is deemed not cost-effective when:
   (1) A Medi-Cal beneficiary is also enrolled in Medicare;
   (2) A court has ordered a non-custodial parent to provide medical insurance;
   (3) An individual or employee has been fully reimbursed for his/her payment of health care premiums; or
   (4) A beneficiary is also enrolled in a Medi-Cal managed care plan.

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