

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.

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.