

## DEPARTMENT OF HEALTH SERVICES

1744 P STREET  
CRAWFORD, CA 95814  
(916) 324-4950



August 24, 1989

Letter: 89-69

TO: ALL COUNTY WELFARE DIRECTORS  
ALL COUNTY ADMINISTRATIVE OFFICERS

SUBJECT: HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

REFERENCE: ACWDL 89-31

This is to notify you that the Health Insurance Premium Payment (HIPP) Program regulations (R-19-87) were approved by the Office of Administrative Law on June 27, 1989. The effective date for implementation of HIPP is August 1, 1989.

As you know, HIPP was enacted through passage of Assembly Bill 3328 (Margolin, Chapter 940, Statutes of 1986). Pursuant to Welfare and Institutions Code Section 14124.91, the Department of Health Services (DHS) is permitted to pay the health insurance premiums for selected Medi-Cal beneficiaries.

For detailed information regarding HIPP, please refer to All County Welfare Directors Letter (ACWDL) 88-60 which provided HIPP background and proposed system information. A second ACWDL 89-31 dated April 27, 1989 provided counties with an update on the status of the program as well as draft HIPP Medi-Cal Manual procedures. Comments provided regarding procedures have been incorporated into the final procedures which are enclosed.

Please advise your eligibility staff of HIPP implementation. We will use the revised Health Insurance Questionnaire (DHS 6155), which is now available to County staff. Telephone referrals will also be accepted by calling 1-800-952-5294.

If you have any questions regarding this matter, please contact Pam Langbehn at (916) 739-3260.

Sincerely,

Original signed by

Frank S. Martucci, Chief  
Medi-Cal Eligibility Branch

Enclosure

cc: Medi-Cal Liaisons  
Medi-Cal Program Consultants

Expiration Date: August 24, 1990

## 15H - - Health Insurance Premium Payment Program

This section provides background information and procedures pertaining to the Health Insurance Premium Payment (HIPP) Program.

### 1. Program Background

The HIPP Program (Welfare and Institution Code, Section 14124.91) was established by enactment of Assembly Bill 3328 (Margolin, Chapter 940, Statutes of 1986). This law authorizes the Department of Health Services, whenever it is cost-effective, to pay health coverage premiums on behalf of Medi-Cal beneficiaries. The primary objective of the program is to continue a Medi-Cal beneficiary's other health coverage by paying medical coverage premiums which the beneficiary cannot afford or if he/she decides to cancel existing coverage. Paying premiums for high cost medical users will result in reducing Medi-Cal costs.

### 2. County Welfare Department (CWD) Responsibilities

The counties' responsibilities are to:

- a. Issue a premium payment referral form (DHS 6155) by:
  - (1) Giving a form to the beneficiary to complete during the application and redetermination process, when the beneficiary indicates:
    - a) that health insurance is available, but has not been applied for, or
    - b) that he/she is about to terminate health insurance coverage or
    - c) that his/her health insurance coverage has lapsed.
- b. Assure that the sections for beneficiary name, Medi-Cal identification number and beneficiary telephone numbers are complete, accurate and readable. If the beneficiary cannot be given the form in person and the beneficiary notifies the County Welfare Department that his/her health insurance has or is about to terminate, or the beneficiary has not applied for the health insurance the EW must complete this portion of the form. The form should then be sent to the beneficiary for signature with a state addressed return envelope. Counties can obtain envelopes when routinely ordering any form stock.
- c. Retain a copy of the referral form in the case folder.
- d. Advise the beneficiary that providing this information will not interfere with eligibility or use of Medi-Cal benefits. However, explain to the beneficiary that private health insurance must be used prior to using Medi-Cal. Information will be used solely to determine if the Department will pay the health insurance premiums for the beneficiary.

- e. Batch and mail the referrals within five (5) days following receipt of the information to:

Department of Health Services  
Recovery Branch  
Health Insurance Unit (HIPP)  
P. O. Box 1287  
Sacramento, CA 95812-1287

- f. After the county receives a confirmation notice that the beneficiary has been accepted to the HIPP program, review and recompute the beneficiary share of cost as necessary in accordance with Articles 12A and 12B (Share of Cost) of the Procedures portion of the Manual.

### 3. Department of Health Services' Responsibilities

- a. DHS will review and process the premium payment referral forms.
- b. DHS will establish a beneficiary case and a tickler file for annual re-evaluation.
- c. DHS will initiate premium payments to the insurance carrier, employer or beneficiary as appropriate.
- d. DHS will update MEDS with the appropriate OHC indicator.
- e. DHS will notify the CWD (DHS 6036A) and the beneficiary (DHS 6167) of the State's approval to purchase health insurance coverage.
- f. DHS will re-evaluate premium payment cases annually. In the event health insurance coverage is discontinued, DHS will 1) change the OHC indicator on MEDS to an "N" and notify the county using the DHS 6036 form to update the case file and, 2) notify the beneficiary of the decision to discontinue him/her from HIPP.

### 4. HIPP Notice (DHS 6036A)

A HIPP notice will be used by the Health Insurance Unit (HIU) to notify the county that the Department has approved payment for a beneficiary's health insurance premium. The notice will provide private health insurance information specific to the Medi-Cal beneficiary. In addition, the notice will indicate the OHC code that the Department will input into the Medi-Cal Eligibility Data System (MEDS).

### 5. Definition of Health Insurance Coverage

For purposes of the HIPP program, the five types of health insurance coverage that will be considered for premium payment are: 1) specific illness plans, 2) indemnity plans, 3) basic coverage, 4) basic/major coverage, and 5) Medicare supplemental plans. In order to determine a beneficiary's coverage type, six questions have been developed and printed on the HIPP referral form (Item No. 5) which should make it easy for a beneficiary to identify his/her type of health insurance coverage. The definitions of these types of health insurance coverage are as follows:

- a. Specific Illness Plan -- Insurance providing an unallocated benefit, subject to a maximum amount, for expenses incurred in connection with the treatment of a specified illness, such as cancer, poliomyelitis, encephalitis and spinal meningitis.
- b. Hospital Indemnity Plan -- Insurance which provides a stipulated daily, weekly or monthly cash payment during hospital confinement.
- c. Basic Coverage -- Insurance which generally provides reimbursement for the major expenses associated with any illness, particularly those arising from hospital stays, physician visits, surgery, and diagnostic tests both in and out of the hospital. Basic plans typically limit coverage in terms of the maximum expense or frequency of utilization of each service that is covered, although benefits for 120 to 365 days of hospital care, for instance, are not uncommon.
- d. Basic/Major Medical Coverage (also known as Comprehensive Major Medical Coverage) -- Insurance designed to give the protection offered by basic coverage and, in addition, provides health insurance to finance the expense of major illness and injury. Basic/major medical coverage is characterized by large benefit maximums ranging up to \$250,000 or having no limit. The insurance, beyond an initial deductible, reimburses the major part of all charges for hospital, doctor, private nurses, medical appliances, prescribed out-of-hospital treatment, and drugs. The insured person as co-insurer pays the remainder. A common basic/major medical coverage type is an 80/20 plan whereby the insurance covers 80 percent of the charge and the insured pays the remaining 20 percent.
- e. Medicare Supplemental Plan -- Insurance coverage for persons who are Medicare eligible. These policies supplement the coverage afforded by the federal government under the Medicare program. Medicare supplemental coverage generally provides the 20 percent co-insurance for Medicare covered outpatient expenses as well as all deductibles. In addition, a medicare supplemental plan also may include custodial care benefits.

6. High Cost Medical Conditions

The following is a nonexclusive list of medical conditions related to high cost medical procedures which will be considered for premium payment. If a beneficiary is identified with an AIDS diagnosis that, case will be automatically accepted for HIPP. Other conditions may be considered on a case-by-case basis:

<u>MEDICAL CONDITION</u>	<u>TREATMENT</u>
1. Breast cancer.....	Mammoplasty
2. Spinal (vertebral arthritides (severe)).....	Osteotomy and fusions
3. Herniated discs.....	" " "
4. Scoliosis.....	" " "

- 32. Vaginal diseases.....Resection & reconstruction
- 33. Abnormal pregnancy & delivery.....C-section
- 34. Brain tumors.....Craniotomy
- 35. Brain hemorrhage & aneurysms.....Craniotomy
- 36. Seizure disorder, pain (Severe).....Stereotactic procedures
- 37. Spinal cord tumors & defects.....Laminectomy
- 38. Nerve defects post trauma.....Nerve grafts
- 39. Corneal defects.....Keratoplasty
- 40. Cataracts.....Lens replacement
- 41. Retinal diseases.....Retinal reattachment
- 42. Strabismus.....Strabismus surgery
- 43. Acquired Immune Deficiency Syndrome (AIDS).....Various

Special Note: Cases which do not pertain to the above medical conditions but involve high dollar medical expense will be evaluated on an individual basis.