DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P.O. Box 942732
Sacramento, CA 94234-7320
(916) 657-2941

November 30, 1995

TO: All County Medi-Cal Program Specialists/Liaisons Letter No.: 95-71

EMPLOYER GROUP HEALTH PLAN PROGRAM HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

This is to provide you with information about the Department of Health Services' (DHS) Employer Group Health Plan (EGHP) and Health Insurance Premium Payment (HIPP) Programs. Additionally, differences between the two programs are explained, allowing workers to better understand how and when thereafter Medi-Cal beneficiaries to either the EGHP or HIPP Program.

1. What are the EGHP and HIPP Programs?

The EGHP and HIPP Programs may, whenever it is cost effective, enroll and pay health insurance premiums for certain Medi-Cal beneficiaries. The objective is to reduce Medi-Cal expenditures by redirecting the cost of medical care to the insurance. The average monthly cost of the beneficiary's health care must be at least twice as much as the monthly insurance premium.

2. What are the differences between the EGHP and HIPP Programs?

To be eligible for the EGHP Program, a beneficiary must have employer-related insurance AVAILABLE to them, or currently have insurance provided through an employer (or family member's employer). To be eligible for the HIPP Program, a beneficiary must currently be enrolled in a health insurance plan (private or group plan).

3. How does a person qualify for either the EGHP or HIPP Program?

In order to qualify for either program, **all** of the requirements listed below must be met:

a. The beneficiary must currently be on Medi-Cal.
b. The beneficiary's share of cost (SOC), if any, must be $200 or less.
c. **EGHP** - The beneficiary's insurance must be available through an employer (or family member's employer).
HIPP - The beneficiary must have a CURRENT health insurance policy, COBRA continuation policy, or a COBRA conversion policy in effect or available at the time of application.

d. The beneficiary must have an expensive medical condition. The average monthly cost of the beneficiary's health care must be at least twice the monthly insurance premium. Any SOC amount will be subtracted from the monthly health care costs to determine if paying the premiums is cost effective.

e. The beneficiary must not be enrolled in a Medi-Cal related prepaid health plan, County Health Initiative, Geographic Managed Care, or the County Medical Services Program (CMSP).

f. The beneficiary's health insurance policy or available health insurance policy must cover the beneficiary's high cost medical condition.

g. The beneficiary's EGHP or HIPP application must be completed and returned in time for the State to process the application and pay the premiums.

h. The beneficiary's health insurance policy must not be issued through the California Major Risk Medical Insurance Board.

4. **How do I make a referral if a Medi-Cal beneficiary currently has health insurance (private or employer related) and has a high cost medical condition?**

Assist the beneficiary in completing the Health Insurance Questionnaire (DHS 6155 - see sample form No. 1 enclosed). In Section I on the document, list the beneficiaries currently covered by the health insurance policy. In Section II on the document, complete questions 1-11. Because it must be cost effective in order for the EGHP or HIPP Program to pay the premiums, it is especially important to provide the name and type of illness of the beneficiary receiving medical treatment in the No. 9 area of the document. Notate "HIPP" at the top of the document and mail the questionnaire to the Department of Health Services, P.O. Box 1287, Sacramento, California 95812-1287.

5. **How do I make a referral if a Medi-Cal beneficiary DOES NOT currently pay for health insurance through an employer (or family member's employer), but health insurance is AVAILABLE and the beneficiary has a medical condition?**

Because the insurance is AVAILABLE through an employer, the beneficiary may be eligible for the EGHP Program. Assist the beneficiary in completing the Health Insurance Questionnaire (DHS 6155 - see sample form No. 2 enclosed). List the beneficiaries who COULD BE covered by the health plan in Section I on the document. In Section II on the document, indicate the name of the AVAILABLE health pan, the name of who the policyholder WOULD BE (who is employed), and the name and address of the employer. Check the No. 6 box indicating "Medical coverage available through employer, but has not been applied for." Because it must be cost effective in order for the EGHP Program

to pay the premiums, it is especially important to provide the name and type of illness of the beneficiary in the No. 9 area of the document. Notate **"EGHP REFERRAL ONLY"** at the top of the document and mail questionnaire to the Department of Health Services, P. O. Box 1287, Sacramento, California 95812-1287. By indicating this is an "EGHP REFERRAL ONLY" you are notifying DHS that the beneficiaries listed DO NOT currently have the insurance, only that it is available to them.

6. **Is it required that a beneficiary have a high cost medical condition in order to qualify for the EGHP or HIPP Program?**

In order to meet the cost effectiveness criteria, the average monthly cost of health care must be at least twice the monthly insurance premiums. Usually, in order to meet this, someone receiving Medi-Cal in the family must have a high cost medical condition.

7. **When I submit an EGHP or HIPP referral on the DHS 6155 to DHS, does that take the place of an application for either program?**

No. By submitting the DHS 6155 to DHS you have simply made a referral to DHS for the EGHP or HIPP Program. If DHS determines after initial screening that your client appears to meet the requirements for either program, an application package will be sent directly to the Medi-Cal beneficiary.

8. **How will I find out if one of my clients has been enrolled into either the EGHP or HIPP Program?**

DHS will main notification to your county that your clients has been enrolled. Additionally, by accessing DHS' Health Insurance Action Request Menu and viewing the Medi-Cal beneficiary's Health Insurance Record (see All County Welfare Directors Letter No. 94-50) you can view "Source" field to determine if the Medi-Cal beneficiary is enrolled in the EGHP or HIPP Program. If the Medi-Cal beneficiary is enrolled in either the EGHP or HIPP Program, the source field will indicate either "EGHP" or "HIPP."

9. **Will the EGHP or HIPP Program pay for health insurance premiums that are past due?**

No. the EGHP or HIPP Program does not make payments for premiums paid prior to application approval, that are past due.

10. **Can the EGHP or HIPP Program pay insurance premiums for a family member who is not receiving Medi-Cal?**

The EGHP Program can pay health insurance premiums for a person who is not Medi-Cal eligible provided that person must be enrolled in the employer's health plan in order to enroll the family members who are on Medi-Cal in the plan.

11. **A Medi-Cal beneficiary's child (who is Medi-Cal eligible) has an absent parent who is supposed to pay for the child's health insurance, but doesn't. Can the EGHP or HIPP Program pay the premiums, as the child has a high cost medical conditions?**

No. The EGHP or HIPP Program cannot purchase or pay any health insurance premiums for a Medi-Cal beneficiary when an absent parent has been ordered by the court to provide medical support.

12. **Once a person is enrolled in either the EGHP or HIPP Program, how long are they eligible?**

The EGHP and HIPP Program staff will reevaluate each case periodically to determine if it is still cost effective for DHS to pay the health insurance premiums. DHS will mail notification to your county notifying you when a Medi-Cal beneficiary is terminated from the EGHP or HIPP Program.

13. **What kind of documentation will my client need to submit to DHS to be enrolled in either the EGHP or HIPP Program and do I need to notify the beneficiary of the required documentation?**

DHS will notify the Medi-Cal beneficiary of information needed. For your information, the following information will be required:

a. A fully completed and signed Health Insurance Premium Payment Application form (DHS 6172 - sample No. 3 enclosed).
b. A copy of the health insurance policy (i.e., booklet, pamphlet, or brochure describing the health plan's, scope of benefits).
c. A copy of a doctor's statement of diagnosis (signed and dated by a physician).
d. <u>If the Medi-Cal beneficiary has health insurance -</u>

(1) A copy of Explanation of Benefits (EOBs) from the health insurance company which details medical costs for a period of six (6) months prior to the month of application.

(2) A copy of the latest premium payment notice or signed COBRA election form, showing: (a) Where the premium is to be sent; (b) the exact amount of the premium; (c) the date the premium is due; and (d) the period of coverage (i.e., monthly, quarterly, etc.)

If the Medi-Cal beneficiary does not currently have health insurance but health insurance is available through an employer -

(1) A statement from the employer (or employer's insurance carrier) indicating the premium cost.

NOTE: DHS will obtain probable future medical cost information from the beneficiary's physician to determine cost effectiveness.

14. Is my client required to apply for either the EGHP or HIPP Program?

Section 50763(a)(1) of the California Code of Regulations requires a Medi-Cal beneficiary to apply for, and/or retain any available health insurance that is provided at no cost. When premium payment by either the EGHP or HIPP Program is found to be cost effective and DHS has started premium payments, the county will be notified by DHS to discontinue Medi-Cal eligibility if the beneficiary terminates enrollment in the health insurance without DHS' approval.

15. **The Medi-Cal beneficiary informed me that his/her health insurance lapsed within the last few months, but the beneficiary does have a medical condition - can I still make a EGHP or HIPP Program referral?**

If the beneficiary has a medical condition, but the beneficiary's health insurance lapsed within the last 60 days, submit and EGHP or HIPP Program referral. If the case appears cost effective, DHS will contact the insurance company and find out if it's possible to reobtain the insurance.

16. **Is there a phone number where the beneficiary can reach either the EGHP or the HIPP Program?**

Yes. To reach the EGHP or HIPP Program, the beneficiary can call toll free 1-800-952-5294, Monday through Friday, 7:30 a.m. to 5:00 p.m. To reach the EGHP or HIPP Program technicians directly, contact the appropriate technician according to the first letter of the beneficiary's last name:

HIPP TECHNICIANS

AAAAA-BUSKA	Yolinda Moguel	(916) 323-9506
BUSKB-FRANC	Helen Springer	(916) 323-8146
FRAND-HRTIC	Becky Pike	(916) 323-7977
HRTID-LYNCH	Maria Serrano	(916) 324-1563
LYNCI-PEREI	Constance Samuels	(916) 323-4837
PEREJ-SMITH	Mary Ballard	(916) 323-5499
SMITI-ZZZZZZ	Evelyn Johnson	(916) 323-8116

EGHP TECHNICIANS

AAAAA-LLLLL	Karla Burbage	(916) 323-4844
MMMMM-ZZZZZ	Suky Lerma	(916) 323-4849

17. **Why would a Medi-Cal beneficiary want to retain their private health insurance when they receive Medi-Cal ?**

a. Beneficiaries can continue health care from their current medical provider.
b. Beneficiaries can receive greater access to medical care by having private health insurance and Medi-Cal.
c. The private health insurance carrier may pay for some services Medi-Cal does not cover.
d. Private health insurance copayments and deductibles may be paid by Medi-Cal. The provider bills the insurance first and then can bill Medi-Cal for the balance once the beneficiary has met his/her SOC. Providers cannot bill Medi-Cal beneficiaries for the cost of covered services.
e. If a Medi-Cal beneficiary has private health insurance, a provider may be willing to treat them as a private pay patient. Some providers are not taking new Medi-Cal patients. The beneficiary's doctor may choose to continue the medical treatment if he/she knows that the beneficiary has private health insurance.
f. If a Medi-Cal beneficiary drops the private health insurance because of Medi-Cal eligibility, it is often times very difficult or impossible to reobtain private health insurance, particularly if the beneficiary has a preexisting medical condition. The EGHP or HIPP Program allows Medi-Cal beneficiaries to obtain/retain private health insurance, at no cost.

If you have any questions regarding the EGHP or HIPP Programs, please contact Ms. Judy Gelein of the HIPP Program, Third Party Liability Branch, at (916) 323-9588.

Sincerely,

ORIGINAL SIGNED BY

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

Sample #1 HIPP

State of California—Health and Welfare Agency | Department of Health Services

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (7:30 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY; HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case Name / Case Address	FOR COUNTY USE ONLY	STATE USE ONLY	
Case Name: Jane A. Doe Case Address: 111 Main St. Sacramento, CA 95620	Worker Number: V762	Verified By:	
	Date: 10/6/95	Date	Initials
	Worker Telephone Number: 916 555-5555	Date	Initials
Initial Intake ☐ Redetermination ☐ HIPP ☐	Optional Dist. No.	Scope	CC #

SECTION I: Beneficiary Information *LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY*

OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	14-DIGIT MEDI-CAL NUMBER: Co. Code	Aid Code	Case Number	FSU	Pers. No.
	Jane A. Doe	123-45-6789	F	1-1-50	34	30	1234567	7	01
	John B. Doe	234-56-7890	M	2-1-80	34	30	1234567	7	02
	Mary C. Doe	345-67-8901	F	3-1-90	34	30	1234567	7	03
		— —							
		— —							

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name: Kaiser
   Address: 123 First Street
   City, State, ZIP: Sacramento, CA 95810
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☒ Yes ☐ No
3. Where do you send your claims?
   Name: N/A
   Address:
   City, State, ZIP:
4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
   Name: Jane A. Doe — Social Security Number: 123-45-6789
   Address: 111 Main St. — Telephone Number: 916 555-1222
   City, State, ZIP: Sacramento, CA 95620 — Absent Parent? ☐ Yes ☒ No
5. What is the policy number? 123-45-6789
6. What are/were the dates of your policy? Beginning Date: 7/1/80 — Ending Date (if applicable): —
   ☐ Medical coverage available through employer, but has not been applied for.
7. Premium Amount: $ 150.00 ☒ Monthly ☐ Quarterly ☐ Yearly
   How are premiums paid? ☐ By Insured to Insurance Carrier ☐ By Employer ☒ By Payroll Deduction
8. Give name of union, employer, group, organization, or school, address, and telephone number.
   Name: Sacramento City School District — Local or Group Number: 123
   Address: 222 North Ave. — Telephone Number: 916 555-6789
   City, State, ZIP: Sacramento, CA 95612
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☒ Yes ☐ No
   If yes, please specify the illness: Mary - Cancer
10. Does your health insurance provide or pay for: (Check all that apply.)
    ☒ Hospital Outpatient (i.e., lab work/ physical therapy) ☒ Prescription Drugs ☐ Long Term Care/Nursing Home
    ☒ Hospital Stays ☐ Dental Care ☐ Only specific illness (i.e., cancer)
    ☒ Doctor Visits ☐ Vision Care Type of Illness:
11. Is the policy a Medicare Supplement? ☐ Yes ☒ No

Remarks:

"By signing this documents, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of Applicant	Home Telephone	Work Telephone	Date
Jane A. Doe	916 555-1222	916 555-6789	10/6/95

RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287

Original—State | Yellow—County File | Pink (Extra Copy-District Attorney-Beneficiary)

DHS 6155 (10/90)

Sample #2

EGHP REFERRAL ONLY

State of California—Health and Welfare Agency

Department of Health Services

HEALTH INSURANCE QUESTIONNAIRE

Please provide all the information requested and return this form to your eligibility worker. Use and attach a copy of your insurance policy, membership card, or any other aid to help complete this questionnaire. PLEASE TYPE OR PRINT. DO NOT ABBREVIATE. Additional instructions and information collection and access are on the reverse. If you have any questions about completing this form or require Spanish translation, call toll-free 1-800-952-5294 (7:30 a.m. to 5:00 p.m.).

COMPLETE THIS FORM FOR ANY HEALTH INSURANCE, INCLUDING MEDICARE SUPPLEMENTS, PREPAID HEALTH PLANS/HEALTH MAINTENANCE ORGANIZATIONS, OR CHAMPUS. HAVING PRIVATE HEALTH INSURANCE DOES NOT AFFECT YOUR MEDI-CAL ELIGIBILITY; HOWEVER, FAILURE TO REPORT OTHER HEALTH INSURANCE MAY BE CAUSE FOR TERMINATION OF YOUR MEDI-CAL ELIGIBILITY.

Case Name: Jane A. Doe	FOR COUNTY USE ONLY	STATE USE ONLY	
Case Address: 111 Main St. Sacramento, CA 95620	Worker Number: V762	Verified By	
	Date: 10/6/95	Date	Initials
	Worker Telephone Number: (916) 555-5555	Date	Initials
Initial Intake ☐ Redetermination ☐ HIPP ☐	*Optional* Dist. No.	Scope	CC #

SECTION I: Beneficiary Information *LIST ALL PERSONS, INCLUDING UNBORNS, ON MEDI-CAL AND COVERED BY HEALTH INSURANCE POLICY*

OHC	Beneficiary Name (First, Middle, Last)	Social Security Number	Sex	Date of Birth	14-DIGIT MEDI-CAL NUMBER: Co. Code	Aid Code	Case Number	FBU	Pers. No.
	Jane A. Doe	123-45-6789	F	1-1-50	34	30	1234567	7	01
	John B. Doe	234-56-7890	M	2-1-80	34	30	1234567	7	02
	Mary C. Doe	345-67-8901	F	3-1-90	34	30	1234567	7	03
		– –							
		– –							

SECTION II: Health Insurance Information

1. What is the name and address of your health insurance company? Include street number, city, state, and ZIP. Do not use abbreviations.
   Name: Kaiser
   Address: 123 First St.
   City, State, ZIP: Sacramento, CA 95810
2. Do you have to obtain medical services from a specific facility or a group of providers? (PHP/HMO/PPO) ☒ Yes ☐ No
3. Where do you send your claims?
   Name: N/A
   Address:
   City, State, ZIP:
4. What is the full name, address, phone number, and SSA number of individual, employee, union member, or person to whom the insurance policy was issued?
   Name: Jane A. Doe — Social Security Number: 123-45-6789
   Address: 111 Main St. — Telephone Number: 916 555-1222
   City, State, ZIP: Sacramento, CA 95620 — Absent Parent? ☐ Yes ☒ No
5. What is the policy number? N/A
6. What are/were the dates of your policy? Beginning Date: N/A — Ending Date (if applicable):
   ☒ Medical coverage available through employer, but has not been applied for.
7. Premium Amount: $ 150.00 ☒ Monthly ☐ Quarterly ☐ Yearly
   How are premiums paid? ☐ By Insured to Insurance Carrier ☐ By Employer ☐ By Payroll Deduction
8. Give name of union; employer, group, organization, or school, address, and telephone number.
   Name: Sacramento City School District — Local or Group Number:
   Address: 222 North Ave. — Telephone Number: (916) 555-6789
   City, State, ZIP: Sacramento, CA 95612
9. Does any covered beneficiary have an acute, chronic, or pre-existing illness that requires him/her to see a physician? ☒ Yes ☐ No
   If yes, please specify the illness: Mary - Cancer
10. Does your health insurance provide or pay for: (Check all that apply.)
    ☒ Hospital Outpatient (i.e., lab work/ physical therapy) ☒ Prescription Drugs ☐ Long Term Care/Nursing Home
    ☒ Hospital Stays ☐ Dental Care ☐ Only specific illness (i.e., cancer)
    ☒ Doctor Visits ☐ Vision Care Type of illness:
11. Is the policy a Medicare Supplement? ☐ Yes ☒ No

Remarks:
Jane, John, & Mary are not currently enrolled in Kaiser - EGHP Referral ONLY!

"By signing this documents, I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, to be used in determining whether the Department will pay my private health insurance premium."

Signature of Applicant	Home Telephone	Work Telephone	Date
Jane A. Doe	916 555-1222	916 555-6789	10/6/95

RETURN COMPLETED FORM TO: RECOVERY BRANCH, P.O. BOX 1287, SACRAMENTO, CA 95812-1287

Original—State Yellow—County File Pink (Extra Copy-District Attorney-Beneficiary)

DHS 6155 (10/90)

SAMPLE #3

State of California—Health and Welfare Agency

Department of Health Services

HEALTH INSURANCE PREMIUM PAYMENT REFERRAL

1. Name of Applicant/Beneficiary

2. Medi-Cal Identification Number

Applicant/Beneficiary Address

3. Social Security Number

City | State | ZIP Code

4. Telephone Number (include area code)

5. Policy Status (Check appropriate box)

a. ☐ Policy will lapse on _____ b. ☐ Policy lapsed on _____ c. ☐ Medical coverage available, but not applied for

6. Type of Coverage Your Insurance Provides or Pays for (Check all that apply):

- ☐ Hospital stays
- ☐ Hospital outpatient (i.e., lab work or physical therapy)
- ☐ Doctor visits
- ☐ Prescription drugs
- ☐ Dental care
- ☐ Vision care
- ☐ Medicare supplement
- ☐ Only specific illness (i.e., cancer)

Type of illness _____

7. Policy Number:

8. Premium Amount

$_____ ☐ Per month ☐ Per year

9. How are Premiums Paid? (Check appropriate box)

a. ☐ Paid by insured to insurance carrier b. ☐ Employer Paid c. ☐ Payroll deducted

10. Name of Insured Policyholder

Social Security number

Address of Insured Policyholder

Telephone Number

11. Name(s) of Other Medi-Cal Eligible Family Member(s) Covered Under the Health Insurance Policy

12. Does Any Covered Beneficiary Have an Acute, Chronic, Pre-existing Illness that Requires Him/Her to see a Physician?

☐ Yes ☐ No If yes, please specify the individual's name and the illness: _____

13. Premium Billing Location (Where Premiums are Mailed and Processed):

Name of Insurance Company, Employer or Union

Address of Insurance Company, Employer or Union

14. Name of Employer:

Address of Employer:

Telephone Number of Employer

15. List Additional Health Insurance Coverage, If Any (Complete a Separate Health Insurance Premium Payment Referral)

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the Department of Health Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the Department of Health Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services which should have been billed to other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42USC, Section 552a) your Social Security number and any information your provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

AUTHORIZATION: "I hereby authorize the Department of Health Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, which may be used in determining if the Department will pay health insurance premiums for continued coverage."

Signature of Applicant/Beneficiary (or Authorized by):

Date: