NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES
NOTICE OF PUBLIC HEARING

October 1, 2018
10:30 a.m. Central Time
Nebraska State Office Building – Lower Level B
301 Centennial Mall South, Lincoln, Nebraska

The purpose of this hearing is to receive comments on proposed changes to Title 471, Chapter 30 of the Nebraska Administrative Code (NAC) – *Health Insurance Premium Payment Program.* The proposed regulations incorporate recent changes to the Medicaid State Plan as approved by the Centers for Medicare and Medicaid (CMS). These regulations replace the previous cost effectiveness calculation used to determine participation in the HIPP program with the calculation recently approved by CMS, clarify the types of insurance coverages allowed for consideration under the HIPP program, and technical changes to streamline and simplify the regulations.

Authority for these regulations is found in Neb. Rev. Stat. § 81-3117(7).

Interested persons may attend the hearing and provide verbal or written comments or mail, fax or email written comments, no later than the day of the hearing to: DHHS Legal Services, PO Box 95026, Lincoln, NE 68509-5026, (402) 742-2382 or dhhs.regulations@nebraska.gov, respectively.

A copy of the proposed changes is available online at http://www.sos.ne.gov, or by contacting DHHS at the mailing address or email above, or by phone at (402) 471-8223. The fiscal impact statement for these proposed changes may be obtained at the office of the Secretary of State, Regulations Division, 1201 N Street, Suite 120, Lincoln, NE 68508, or by calling (402) 471-2385.

Auxiliary aids or reasonable accommodations needed to participate in a hearing can be requested by calling (402) 471-8223. Individuals with hearing impairments may call DHHS at (402) 471-9570 (voice and TDD) or the Nebraska Relay System at 711 or (800) 833-7352 TDD at least 2 weeks prior to the hearing.

FISCAL IMPACT STATEMENT

Please check one.
☐ **Draft** ☒ **Final**

Has this statement been reviewed & approved by FAPA Unit (MLTC & CFS) or Budget Unit (PH)? ☒ **Yes** ☐ **No**

Agency: **Department of Health and Human Services**	
Title: 471	Prepared by: Carrie Priefert
Chapter: 30	Date prepared: 7.2.18
Subject: Health Insurance Premium Payment Program	Telephone: 402.471.9336

Type of Fiscal Impact:

Please check all that apply

	State Agency	Political Sub.	Regulated Public
No Fiscal Impact	(☒)	(☒)	(☒)
Increased Costs	(☐)	(☐)	(☐)
Decreased Costs	(☐)	(☐)	(☐)
Increased Revenue	(☐)	(☐)	(☐)
Decreased Revenue	(☐)	(☐)	(☐)
Indeterminable	(☐)	(☐)	(☐)

Provide an Estimated Cost & Description of Impact:

State Agency:

Political Subdivision:

Regulated Public:

If indeterminable, explain why:

TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 30 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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TITLE 471 NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 30 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

001. SCOPE AND AUTHORITY. The regulations govern the services provided under Nebraska's Medicaid program as defined by Nebraska Revised Statute (Neb. Rev. Stat.) §§ 68-901 to 68-991 (the Medical Assistance Act). The Health Insurance Premium Payment (HIPP) Program is authorized under §§1905 and 1906 of the Social Security Act.

002. DEFINITIONS. The following definitions apply:

002.01 COST EFFECTIVENESS. A determination, made by the Department, that payment for coverage under a group health plan or individual market health plan will be less than the amount of expenditures under the Nebraska Medicaid State Plan that Medicaid would have made to provide comparable coverage for the client.

002.02 GROUP HEALTH PLAN. Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of employees or former employees. A group health plan must meet S. 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Services Act, S. 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974.

002.03 INDIVIDUAL MARKET HEALTH PLAN. Individual market is the market for health insurance coverage offered to individuals other than in connection with a group health plan. For purposes of the Health Insurance Premium Payment (HIPP) Program, individual market policies include health plans that comply with the requirements of the Patient Protection and Affordable Care Act of 2010 (ACA) and may include policies that do not meet all Affordable Care Act (ACA) requirements but are still found to provide comprehensive health coverage as determined by the Department.

003. PARTICIPATION IN THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM.

003.01 VOLUNTARY PARTICIPATION IN HEALTH INSURANCE PREMIUM PAYMENT (HIPP). Participation in the Health Insurance Premium Payment (HIPP) Program is voluntary. For Medicaid eligible clients, enrollment in the Health Insurance Premium Payment (HIPP) Program does not change the client's eligibility for benefits through the state plan or cost sharing obligations under the state plan.

003.02 PARTICIPATION DETERMINATION FOR HEALTH INSURANCE PREMIUMPAYMENT (HIPP).

003.02(A) REQUIRED DOCUMENTATION. The Department may request any documentation from the client that it deems to be necessary to determine whether the client's enrollment in an available group health plan or individual market health plan is cost effective. Documentation that must be submitted includes, but is not limited to:

(i) Signed application for enrollment in the Health Insurance Premium Payment (HIPP) Program;
(ii) Summary of covered benefits from the group health plan or individual market health plan;
(iii) If applicable, verification of the client's ongoing medical diagnosis. Verification must be provided by an appropriate physician or entity;
(iv) Completed verification form for employer sponsored insurance; and
(v) Monthly proof of health insurance premium payments.

003.03 EFFECTIVE DATE OF PARTICIPATION IN THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM. The effective date for Health Insurance Premium Payment (HIPP) participation is the first day of the month that the following criteria are met:

(A) The client is enrolled in a group health plan or individual market health plan;
(B) All documentation necessary for Medicaid to determine cost effectiveness has been submitted; and
(C) The Department has determined that the client's participation in Health Insurance Premium Payment (HIPP) would be cost effective.

003.04 COST-EFFECTIVENESS DETERMINATION. The Department determines the cost-effectiveness for payment of qualifying group health insurance or individual market health insurance premiums.

003.04(A) COST-EFFECTIVE MEDICAL CONDITIONS. Any Medicaid-eligible client who has an existing, ongoing, medically confirmed medical condition determined by the Department to be considered a cost-effective condition, is deemed to meet the cost-effective criteria.

003.04(B) COST-EFFECTIVENESS CALCULATION. When the criteria of 471 Nebraska Administrative Code (NAC) 30-003.03(A) are not met, cost-effectiveness will be calculated as follows:

(i) Determine the annual anticipated cost for Medicaid services generally covered by the private health insurance based on the client's age, sex, and eligibility category;
(ii) Total the results of each of the following calculations:
  (1) The portion of the group health insurance or individual market health insurance premium payable by the Health Insurance Premium Payment (HIPP) program;
  (2) A predetermined annual administration cost per participant; and
  (3) The expected cost to Medicaid for any deductibles, coinsurance, or copayments.
(iii) Subtract the result of (ii) from the result of (i);

(iv) If the result is greater than or equal to $10, the policy would be determined cost effective; and
(v) If the result is less than $10, the policy would not be considered cost effective.

003.04(C) SUPPLEMENTAL INFORMATION. When the criteria of 471 NAC 30-003.04(A) and 471 NAC 30-004.03(B) are not met, specific information relating to the individual circumstances of the Medicaid-eligible client may be provided. On a case-by-case basis and at the sole discretion of the Department, a determination of cost effectiveness can be made if sufficient evidence is provided to demonstrate savings to Medicaid.

003.04(D) EXCLUDED CASES. The Department will not make a determination of cost effectiveness in the following circumstances:
(i) The client is eligible for or enrolled in Medicare;
(ii) Payment of health insurance premiums have been fully reimbursed or offset by a third party, including, but not limited to:
(1) An employer; or
(2) An individual court-ordered to provide medical support.
(iii) The recipient is only eligible for a medically needy, spend-down, program; or
(iv) The group health insurance or individual market health insurance only provides catastrophic, limited benefit, limited duration, or indemnity coverage.

003.04(E) MULTIPLE POLICIES. When more than one group or individual market health insurance policy is available, the Department shall pay only for the most cost-effective policy.

003.04(E)(i) EXCEPTION FOR SUPPLEMENTAL POLICIES. At the sole discretion of the Department, in the circumstance when an additional supplemental policy is available and that policy is found to provide coverage that does not duplicate coverage included in the primary health insurance plan, the Department may include both the primary health plan and supplemental policy in its cost-effectiveness calculation. If the Department finds that paying the costs described in 471 NAC 30-003.04 for both the primary and supplemental health policies is more cost effective than paying solely for the costs of the primary health policy, the Department may pay for the costs of both the primary and supplemental health policies.

003.04(F) REDETERMINATIONS.

003.04(F)(i) ANNUAL REDETERMINATION. The Department conducts a redetermination of participation annually for all clients enrolled in the Health Insurance Premium Payment (HIPP) Program. This redetermination includes:
(1) Verification of eligibility for Medicaid; and
(2) Completion of the cost-effective calculation as outlined in 471 NAC 30-004.03(A) through 30-004.03(C).

003.04(F)(ii) CHANGES IN CIRCUMSTANCES. A redetermination of participation may be conducted at any point if:

(1) The monthly premium of the group health insurance or individual market health insurance increases by more than $50;
(2) There is a change in eligibility category or status for Medicaid;
(3) The services offered by the group health insurance or individual market health insurance decrease;
(4) There is a change in the deductible, co-insurance, or any other cost-sharing provisions of the group health policy or individual market health policy; or
(5) There is reason to believe a change has occurred which may affect participation for Health Insurance Premium Payment (HIPP) enrollment.

The client has an affirmative obligation to report any change in circumstances.

003.05 TERMINATION OF HEALTH INSURANCE PREMUIM PAYMENT (HIPP) PARTICIPATION. Failure to provide requested documentation in accordance with 471 NAC 30-003.02(A), or failure to meet Health Insurance Premium Payment (HIPP) enrollment participation criteria as outlined in 471 NAC 30-004.01 and 30-004.03, may result in termination of participation in the Health Insurance Premium Payment (HIPP) Program.

004. REIMBURSEMENTS. Medicaid covers reimbursement of premiums for Medicaid-eligible enrollees in a cost effective group health plan or individual market health plan. Medicaid also covers payment of all deductibles, coinsurance, and other cost sharing obligations under the group health plan or individual market health plan that are for services covered under the Medicaid State Plan.

Reimbursements will be made directly to the policyholder as a reimbursement for the group health insurance or individual market health insurance premiums. The client or policyholder must submit accompanying documentation within sixty days of the date paid showing the premium payment has been made.

004.01 FAMILY MEMBERS. If a family member who is not eligible for Medicaid must be enrolled in the group health plan or individual market health plan to obtain coverage under the group health plan or individual market health plan for the Medicaid-eligible client, Medicaid covers payment for the group health plan premiums for the family member who is not eligible for Medicaid.

004.02 DEDUCTIBLES, COINSURANCE, AND OTHER COST SHARING. The Department will pay deductibles, co-insurance, and cost sharing obligations up to the Medicaid allowable amounts directly to the enrolled Medicaid provider. The provider must submit a claim to the Department in accordance with claim submission and payment guidelines outlined in 471 NAC Chapters 2 and 3, as well as any submission and payment guidelines included within each service specific NAC Title 471 Chapter directly. Payment will be made directly to the provider in an amount up to, but not exceeding, the Medicaid allowable amount less any payment made to the provider by the group health plan or individual market health plan. The provider must accept Medicaid payment as payment in full, and cannot bill the client for the difference between the Medicaid payment and the billed amount.

Prior to submitting a claim to the Department for payment, the provider must complete the provider enrollment process outlined in 471 NAC Chapter 2 as well as any enrollment requirements included within each service specific NAC Title 471 Chapter.

004.02(A) FAMILY MEMBERS. Medicaid does not cover deductibles, coinsurance, and other cost sharing obligations under the group health plan or individual market health plan for any family member who is not eligible for Medicaid.

004.03 SERVICES COVERED BY MEDICAID. A client's enrollment in a group health plan or individual market health plan does not change the client's eligibility for benefits under Medicaid. If services covered under Medicaid are not covered by the group health plan or individual market health plan, the client may obtain these services from Medicaid-enrolled providers. Coverage of, and payment for those services is made according 471 NAC Chapters 1, 2, and 3, as well as well as any coverage and payment requirements included within each service specific NAC Title 471 Chapter. If a client is enrolled in Managed Care to obtain services, the coverage and subsequent payment for those services will be in accordance with the Managed Care entities' coverage and payment guidelines.

004.04 SERVICES NOT COVERED BY MEDICAID. Medicaid does not pay for the deductibles, coinsurance, and other cost sharing obligations for services covered under the client's group health plan or individual market health plan that are not covered under the Nebraska Medicaid State Plan.

004.05 MEDICARE ENROLLMENT. If the client is also eligible for Medicare but is not enrolled in Medicare, Medicaid does not pay for the premiums or other cost sharing obligations to the group health plan or individual market health insurance.

005. CLIENTS RIGHT TO APPEAL. The Health Insurance Premium Payment (HIPP) Program is intended to serve as a cost saving measure for Medicaid, and does not confer any additional benefits upon the client. Accordingly, the client does not have the right to appeal an adverse decision regarding enrollment or participation in the Health Insurance Premium Payment (HIPP) Program.

30-000 Payment for Health Insurance Premiums

30-001 Introduction: The Nebraska Medical Assistance Program covers payment for health insurance premiums for individuals who are otherwise eligible for Medicaid when determined to be cost effective. This chapter contains the rules and regulations that apply to this benefit. Conditions of eligibility are addressed in Titles 468, 469, 470, 477, and 479.

30-001.01 Legal Basis: Sections 1905(a) and 1906 of the Social Security Act requires each state Medicaid program to provide this benefit.

30-001.02 Definitions: The following definitions apply to this benefit:

Cost Effectiveness: A determination, made by the Department, that the amount that the Nebraska Medical Assistance Program would pay for premiums, coinsurance, deductibles and other cost sharing obligations under a health plan, plus an amount for administrative costs is likely to be less than the amount paid for an equivalent set of Medicaid services.

Group Health Plan: Any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of employees or former employees. A group health plan must meet S. 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Services Act, S. 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974.

Health Plan: Any health insurance plan that, in exchange for premiums paid, pays benefits for medical services. Excluding Medicare Part B premiums (see 471 NAC 1-007).

30-002 Covered Benefits: The Nebraska Medical Assistance Program covers payment of premiums for Medicaid-eligible enrollees in a cost effective health plan. NMAP also covers payment of all deductibles, co-insurance, and other cost sharing obligations under the health plan that are for services covered under NMAP.

30-002.01 Family Members: If a family member who is not eligible for Medicaid must be enrolled in the health plan to obtain coverage for the Medicaid-eligible client, NMAP covers payment only for the premiums; no other cost sharing expenses are covered. The family member may reside in a different household.

30-002.02 Services Covered by NMAP: A client's enrollment in a health plan does not change the client's eligibility for benefits under the Nebraska Medical Assistance Program. If services covered under NMAP are not covered by the health plan, the client may obtain those services from Medicaid-enrolled providers. Payment for those services is made according to the payment methodology currently in effect under NMAP.

If the client's health plan offers more services than covered under NMAP, NMAP does not pay for the deductibles, coinsurance, and other cost sharing obligations for non-covered services.

30-002.03 Medicare Enrollment: If the client is also eligible for Medicare Part B but is not enrolled in Medicare Part B, NMAP does not pay for the premiums or other cost sharing obligations to the health plan.

30-002.04 Cost Sharing Amounts Under NMAP: If the client is required to pay cost sharing amounts under NMAP, payment of the cost sharing amounts are not covered as a benefit under this chapter.

30-002.05 Available Resource: The health plan is considered an available third party resource.

30-003 Enrollment in a Group Health Plan: Group health plans usually limit an individual's enrollment period. If an individual who is already enrolled in a group health plan becomes Medicaid-eligible, NMAP buys into the group health plan as of the effective date of Medicaid eligibility.

30-003.01 Effective Date of Benefit: If a client is not eligible for coverage under a group health plan for a specified waiting period, NMAP buys into the group health plan as of the effective date of eligibility for the group health plan. Until the client is eligible to enroll or entitled to receive services under the group health plan, all Medicaid-covered services are covered and paid under the usual policies and procedures of NMAP.

30-003.02 Delayed Enrollment: If the availability for enrollment in the group health plan and eligibility for Medicaid do not coincide, the client/applicant shall apply for the group health plan (by completing the necessary forms if available). The enrollment application is held until open season and then the form is submitted.

The client/applicant is not eligible for Medicaid if s/he refuses to apply for enrollment in a group health plan. This ineligibility is effective until the next open season for group health plan enrollment.

30-004 Cost Effectiveness Determination: The Nebraska Medical Assistance Program (NMAP) determines the cost effectiveness of health plans using the following methodology:

1. Obtain information on the health plan available to the client. This information must include the effective date of the policy, exclusions to enrollment, the covered services under the policy, riders and exclusions of covered services, and premiums paid by the policy owners.
2. Using the Medicaid Management Information System (MMIS), obtain the total six-month estimated average Medicaid costs of persons like the applicant (age, sex, and category data). Adjust this amount for inflation.
3. Determine the amount of the total six-month Medicaid expenditures that are spent on the services covered by the individual policy, using the following categories: drugs, practitioner services (this includes physician services, durable medical equipment, other practitioners, etc.), inpatient hospital services, outpatient hospital services, and home health services.
4. Estimate the cost of coinsurance and deductibles up to the allowable amounts under the Nebraska Medical Assistance Program.
5. Determine the administrative cost to Medicaid for processing the health plan information by determining the average increase in cost per client for the six-month period.
6. Determine the cost to Medicaid with insurance by adding the following:
   a. The administrative cost determined under item 5;
   b. The coinsurance and deductible cost determined under item 4;
   c. The premium cost (The premium cost is determined by applying a premium factor for the percentage of clients who would receive services compared to those eligible for Medicaid. This accounts for Nebraska's costs being based on "per client" data instead of "per eligible" data.); and
   d. The cost of non-covered services (subtract item 3 from item 2);
7. Compare the cost to Medicaid with insurance (item 6) to the estimated average Medicaid costs (item 2). If the cost to Medicaid with insurance is less than the estimated average Medicaid costs, the health plan is cost effective. If the cost to Medicaid with insurance is equal to or greater than the estimated average Medicaid costs, the health plan is not cost effective.

30-004.01 Exceptional Medical Costs: If the client provides documentation of on-going medical costs that exceed the estimated average Medicaid costs (see item 2 in 471 NAC 30-004), NMAP may determine that the health plan is cost effective.

30-004.02 Spenddown Cases: NMAP has determined that payment of premiums for a health plan is not cost effective when the premium is used to meet a spenddown obligation under the medically needy program.

30-004.03 Non-Covered Benefits: NMAP has determined that payment of premiums for a health plan is not cost effective for the eligibility category of Aged.

NMAP does not pay premiums for health plans that are the court-ordered obligation of an absent parent.

30-005 Balance Billing: Medicaid pays only up to the amount allowed under the Nebraska Medical Assistance Program. For example, if a provider bills $50 for a service and the insurer pays $40, but the Medicaid allowable is $37, Medicaid will not make up the $10 difference between the billed amount and the insurance payment; NOR CAN THE PROVIDER BILL THE CLIENT. If the provider bills $50 and the insurance pays $37 and the Medicaid allowable is $40, Medicaid can pay the difference, up to the Medicaid allowable - in this case, Medicaid pays $3. THE PROVIDER CANNOT BILL THE CLIENT FOR THE DIFFERENCE BETWEEN THE MEDICAID PAYMENT AND THE BILLED AMOUNT.

30-006 Payment for Services: NMAP will pay the health insurance premium directly to the insurance carrier. If payment cannot be made directly to the carrier and the method of premium payment is payroll deduction, NMAP will arrange to pay the employer directly in lieu of the payroll deduction. If payment cannot be made directly to the carrier or employer, NMAP will reimburse the policyholder for the payroll deduction made for health insurance.

Some providers that participate in health plans may not be Medicaid participating providers. These providers will be encouraged to participate. Provider participation may be initiated through the submission of a bill for services. If providers refuse to bill Medicaid, NMAP may make payment directly to the client or financially responsible individual for the payment of coinsurance and deductible, up to the Medicaid allowable amount.