COMMONWEALTH of VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
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Agency Response to Economic Impact Analysis

The Department of Medical Assistance Services has reviewed the Economic Impact Analysis prepared by the Department of Planning and Budget regarding the regulations concerning the HIPP program, 12 VAC-30-20-210. The Department concurs with the greater part of the analysis, but wishes to clarify one major point from the Agency's standpoint.

The HIPP regulations require a cost effectiveness determination of the employer health plan for enrollment. Cost effectiveness here means that it costs the state less to pay the employee's share of the family health insurance premium and cost sharing, than pay the full medical costs for the enrollee. As a result of Medicaid eligibility rules, there are circumstances that allow a Medicaid applicant to be Medicaid eligible without regard for the income of the applicant's family. Such enrollees are likely to be covered under a family health insurance policy that includes family members who are not enrolled in Medicaid. Under the current changes being made in this regulation, a family that has family health coverage for three or more non-Medicaid family members would not be eligible for the HIPP program. Most families in these circumstances would have the family health coverage even if Medicaid were not paying their family premiums. Because the HIPP program is intended for families that cannot afford health insurance premiums, DMAS determined that it will no longer enroll Medicaid recipients in HIPP who would otherwise retain family coverage. These enrollees do not lose their Medicaid coverage. This regulatory change means, however, that DMAS will no longer make premium payments for both Medicaid and non-Medicaid family members.

DPB suggests an alternative approach in which the Agency makes prorated premium payments based upon the number of non-Medicaid members in the family. This approach, however, creates an untenable administrative burden on the Agency that would likely outweigh its fiscal benefits. In response to DPB's concerns, DMAS intends to revise the final HIPP regulations to create two exceptions for families with financial need who would be ineligible for the HIPP under the new rule. The first exception is for families who have a family health plan with 3 or family members not enrolled in Medicaid but have family income below the family income limit for eligibility. Some

families have children have aged out of Medicaid eligibility but are still covered under the family's insurance. With Health Care Reform, children can remain enrolled in a parent's health plan until age 26, so this change should address this issue in part.

The second exception is for families where at least 1 child is enrolled in Medicaid and the family would meet the income eligibility criteria for the Family Access to Medicaid Insurance Security (FAMIS) program, but because they have health insurance they are not eligible for FAMIS. In both types of these cases described here, where the family income is below the Medicaid or FAMIS income limits, the families will be considered for HIPP participation.

In addition, effective October 1, 2010, DMAS will be expanding the HIPP program by adopting the optional premium assistance program available under 1906(A) of the Social Security Act. While this program is targeted toward Medicaid eligible children under the age of 19, it does not exclude existing family health plans. Therefore, some cases denied or canceled under the current HIPP regulations may meet the criteria under the 1906(A) premium assistance program. 1906A utilizes a more simplistic cost effective evaluation which only requires that the employer contribute at least 40% of the health insurance cost. DMAS intends to contact policy holders canceled from HIPP or denied participation under the current regulations to inform them of the expanded program available under 1906(A) for which they may be eligible.

DMAS acknowledges that a family may elect to drop a Medicaid-enrolled family member from their health plan if they are excluded from the HIPP program. However, from a review of cases affected by the new policy DMAS has concluded that families continue their private insurance regardless of whether HIPP premium assistance is available. If, in light of this regulatory change, a family drops the Medicaid eligible individual from the family plan, their estimated private premium costs will not decrease. It is far more likely that such families will keep the Medicaid eligible on their private health plan where it makes no difference in the amount of their premium.

DMAS continues to monitor the impact of the cases that have been canceled or denied premium assistance to determine those situations in which the Medicaid eligible has been removed from the family health plan. The Agency will analyze these findings to determine if further modification to the regulations is warranted.