

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**  
**State/Territory: Alabama**

**1906 of the Act      State Method on Cost Effectiveness of Employer–Based Group Health Plans (Private Health Insurance Buy In – PHIBI)**

The State of Alabama will use two methods to determine the likely cost effectiveness of a group health plan:

1. Cost effectiveness based on Average Expenditure Projection

The likely cost effectiveness of a health insurance policy to Medicaid may be determined by comparing the cost of the premiums, deductibles, copayments, plus the administrative cost of analysis and processing by the state against the average Medicaid expenditure for a recipient in the recipient's eligibility classification for types of service(s) covered under the policy. The premium shall be paid even if the policy covers other non-Medicaid person(s), but only to the extent when the premium portion of the recipient cannot be paid separately from the non-covered person.

2. Cost Effectiveness Based on Actual Expenditures

The likely cost effectiveness of health insurance may be established by documentation of actual expenditures (Explanation of Benefits) from the insurer which, based on a recipient's existing condition, are likely to continue and that exceed the cost of the policy as described in paragraph 1. above for the period of anticipated Medicaid coverage.

**Methodology for Determining Cost Effectiveness of the Health Insurance Premium Payment Program (HIPP)**

The purpose of the Health Insurance Premium Payment Program (HIPP) is to identify Medicaid cases in which payment of employer related group health insurance premiums would be cost effective.

In order to qualify for HIPP, a person must be eligible for and receiving Medicaid, participate in a group health insurance plan, and payment of the health insurance premium by the Alabama Medicaid Agency must be determined to be cost effective. The recipient or a person acting on the recipient's behalf shall cooperate in providing information necessary for the Agency to establish availability and the cost effectiveness of group health insurance.

### **THIRD PARTY LIABILITY**

Once a person is determined eligible for HIPP, the insurance will be treated as a third party resource. The policy will be listed on our third party file. The group insurance will become the primary payer. Medicaid will provide for payment of items and services to Medicaid recipients under the State Plan that are not covered in the group health plan.

### **COST EFFECTIVENESS**

Cost effectiveness means that Medicaid payments for certain services will probably be greater than the cost of paying the health insurance premiums for those services. When determining if a health insurance plan is cost effective, the following data will be considered:

- The cost of the insurance premium, coinsurance and deductibles
- The category of services covered under the insurance plan, including exclusions for pre-existing conditions, etc.
- The average anticipated Medicaid use, by coverage group, for person covered under the insurance plan
- The specific health related circumstances of the person covered under the insurance plan

### **COVERAGE OF NON-MEDICAID ELIGIBLE FAMILY MEMBERS**

When it is determined to be cost effective, the Agency will pay for health insurance premiums for Non-Medicaid eligible family members if a Non-Medicaid eligible family member must be enrolled in the health insurance plan in order to obtain coverage for the Medicaid eligible family members. The needs of the person/persons not covered by

Medicaid will not be taken into consideration in determining cost effectiveness. Payments of deductibles and coinsurance will not be made on behalf of family members who are not Medicaid eligible.

### **EXCEPTIONS TO PAYMENT**

Health insurance premiums will not be paid under the following circumstances:

- The insurance plan is that of an absent parent
- The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (example: \$50.00 per day for hospital services instead of 80 percent of the charge)
- The insurance plan is a school plan offered on the basis of attendance or enrollment at the school
- The person/persons covered under the plan are not Medicaid eligible on the date the decision regarding eligibility for HIPP is made.

### **DUPLICATE POLICIES**

When more than one health insurance plan or policy is available to a recipient, the Agency will pay for the most cost effective plan. In a situation where a recipient is on Buy-in (the Agency is paying the cost of the Medicare Part A or Part B premiums), the cost of premiums for a Medicare supplemental insurance policy may be paid if the Agency determines it to be cost effective.

### **DISCONTINUATION OF PREMIUM PAYMENTS**

When a recipient loses Medicaid eligibility, premiums payments will be discontinued as of the month of Medicaid ineligibility. When part of a household loses Medicaid eligibility, a review will be completed in order to determine whether or not payment or the health insurance premium continues to be cost effective.

### **EFFECTIVE DATE OF PREMIUM PAYMENT**

The effective date of premium payments for cost effective health insurance plans will be the month in which the plan is determined to become cost effective as long as all necessary requirements have been met (e.g., Cobra forms are on file with employer, HIPP application is on file with Third Party, etc.).

### **REVIEW OF COST EFFECTIVENESS**

A redetermination of cost effectiveness will be completed at least every six months for employer related group health plans and annually for non-employer related group health plans. Also, redeterminations will be completed whenever a predetermined premium rate, deductible or coinsurance increases, a person covered under the policy loses full Medicaid eligibility or there is a decrease in services covered under the policy.

### **TIME FRAMES FOR DETERMINING COST EFFECTIVENESS**

The Agency will determine cost effectiveness of the insurance plan and notify the recipient of the decision regarding payment of premiums within 45 days of the receipt of the HIPP application. Additional time may be granted when, for reasons beyond the control of the Agency or recipient, information needed to establish cost effectiveness cannot be obtained within the 45 day period.

### **NOTICES**

An adequate notice shall be provided to the Medicaid recipient or person responsible for the recipient under the following circumstances:

- To inform the recipient of the initial decision regarding cost effectiveness and premium payment
- To inform the recipient that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the policy
- To inform recipient that premium payments are being discontinued because the insurance plan is no longer available (e.g., employer drops insurance coverage or the insurance company terminates the policy)
- To inform recipient that payment of premiums is being discontinued because the Agency has determined the policy is no longer cost effective.

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TN No. AL-09-003

Supersedes

TN No. New

Approval Date: 09/29/09

Effective Date: 08/01/09

**RATE REFUND**

The Agency will be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due, because of lower than anticipated claims for any period of time for which the Agency paid the premium.