

HIPP Program Participation *Overview*

The Health Insurance Premium Payment (HIPP) Program provides health insurance premium assistance when it has been determined to be cost-effective. Reimbursement occurs monthly and is based upon information showing that you paid your premium in the prior month. When payments are issued, they are reimbursement for premium costs you incurred in the prior month.

When HIPP reimbursement is based upon the actual cost of health insurance premium rather than the HIPP cost effectiveness rate (see Tab D for explanation of HIPP cost effectiveness rates), the costs for the premiums are averaged over a 12 month time period to determine the monthly reimbursement. HIPP analysts calculate the cost based upon the payroll deduction multiplied by the number of pay period deductions annually and divide that amount by 12 to determine the monthly reimbursement amount. At the time of member's annual review, payments issued by HIPP will be reconciled with paystub information to ensure no overpayment or underpayment has occurred. If an overpayment has occurred, subsequent HIPP payments will be adjusted to recover the overpayment. If an underpayment has occurred, supplemental payment will be issued. If an overpayment occurred and the case is no longer participating in the HIPP program, referral will be sent to the Recipient Audit Unit at DMAS to seek recovery of the overpayment.

1. You must send in premium payment documentation by the 5th of each month. Please write your Name and HIPP case number on all correspondence you submit to the HIPP Program to help identify your case. *See Tab B and C.*
2. For family members covered under your employer's health insurance and who are also Medicaid eligible, your employer's health insurance coverage is primary. Ensure that you give medical providers both the employer's insurance card and the Medicaid card.

The following applies to the Medicaid eligible family members:

- a. When receiving services, co-payments and deductibles may be paid if using a Medicaid provider. The Medicaid provider will submit the claim to Medicaid.
 - b. If a medical service is not covered by your employer's insurance but is covered by Medicaid, Medicaid may pay for the service as long as you see a Medicaid provider.
- c. Medicaid providers are listed on the DMAS website at www.dmas.virginia.gov/provider_search.ASP, or you can contact the Recipient Help Line at (804) 786-6145.
3. Reimbursement payments will be sent monthly as long as HIPP eligibility requirements are met. *Please see Tab D.*
 4. Changes in information must be reported within 10 business days and will be evaluated for continued HIPP eligibility. Changes in coverage may affect the premium assistance amount and/or continued participation in the HIPP program.
 5. You must also report changes to your Medicaid caseworker at your local Department of Social Services (DSS).
 6. If you choose to disenroll from your employer's health insurance coverage, you or your family members Medicaid eligibility will not be affected.
 7. Effective June 1, 2011, participants in the DMAS HIPP Program will be able to send information to the HIPP Unit by fax, email or regular mail:

- Fax documents to the HIPP Unit at 804-225-4393
- Email scanned documents to HIPPcustomerservice@dmas.virginia.gov, or
- Mail by requesting postage paid envelopes by phoning Commonwealth Martin at 804-780-0076 and asking for “2060 HIPP Unit envelopes.”