

Health Insurance Premium Payment (HIPP)

Program Manual



Department of Medical Assistance Services

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I. General Information

1. Introduction

The Health Insurance Premium Payment (HIPP) Program is a cost saving program administered by the Department of Medical Assistance Services (DMAS) for Medicaid *enrollees*, which, when it is determined to be cost effective, *reimburses some or all of* the employee portion of the group health insurance premium for *enrollees* who have *employer sponsored group* health insurance available to them through their own or their family member's employment.

2. Legal Base

The HIPP program is established under Section 1906 of the of the Social Security Act. Effective July 23, 2009, the HIPP program became an optional program under the Medicaid Program. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid HIPP program in Virginia; 12VAC30-20-210, State method on cost effectiveness of employer-based group health plans; 12VAC30-20-211 (emergency regulations), State method on cost effectiveness of employer-based group health plans – individual and family plans; 12VAC30-130-750, Time frames for determining cost effectiveness; and 12VAC30-130-790. Information required of applicants and recipients.

3. Program Information

Information regarding the HIPP program is available on the DMAS website at <http://www.dmas.virginia.gov/rcp-HIPP.htm> or by calling 800-432-5924.

II. Confidentiality

HIPP applicants and recipients are protected by Medicaid federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

1. Release of Participant Information

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any participant information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid HIPP program, which includes but is not limited to:

- establishing eligibility,
- determining the amount of premium subsidy assistance, and,
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

2. Release to Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives. The designation must be in writing, with the applicant or participant specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

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3. Safeguarding Client Information

All information associated with an applicant or participant that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the participant;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;
- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of premium assistance subsidy payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

4. Ownership of Records

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated. Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

5. Release of Participant Information with Consent Form

As part of the application process for HIPP, the participant shall be informed of the need to consent to the release of information necessary for verifying eligibility. Additionally, whenever an application is received and the Medicaid enrollee family member is not living in the same household as the employee/policyholder with the insurance coverage, a HIPP Consent Form must be received from both:

1. the parent/legal guardian of the household in which the Medicaid enrollee resides or the Medicaid enrollee if age 18 or older
2. the policy holder of the insurance coverage

6. Release of Participant Information without Consent Form

Information from the applicant/participants case record may not be released to other agencies, with the exception of the Department of Social Services without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with INS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in these situations:

- to employees of state and local departments of social services for the purpose of program administration;
- to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;
- between state/local department of social services staff and DMAS for the purpose of supervision and reporting;

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- to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and
- for the purpose of recovery of monies for which third parties are liable for payment of claims.

7. Client's Right of Access to Information

- A. Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:
- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
 - Information that would breach another individual's right to confidentiality.
- B. Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.
- C. The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:
- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,
 - The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.
- D. Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified. When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

III. Definitions

Applicant means the person who signed the HIPP Application Form, may be the parent or guardian living in the same household with the Medicaid eligible family member, the parent or guardian who is employed and is the policy holder of the insurance coverage, or the Medicaid eligible family member if age 18 or older.

Authorized Representative	means a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement. The authorized representative statement is valid until: <ul style="list-style-type: none"> • the application is denied; • the premium assistance enrollment is canceled; or • the individual changes his authorized representative
Case	means all persons who are living in the same household who are eligible for coverage under the group health plan and who are eligible for Medicaid
COBRA	means the Consolidated Omnibus Budget Reconciliation Act (COBRA) which gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances
Comprehensive Health Coverage	means coverage that is comparable to services offered under the Medicaid State Plan and provide at a minimum the following services; physician services, in and outpatient hospitalization, prescription drugs, outpatient labs, shots and x-rays.
Cost Effective and Cost Effectiveness	means that it is likely to cost the state less to pay for the premiums of employer sponsored health insurance including the copayments and other cost sharing amounts than to otherwise cover under the Medicaid program
Family Member	means individuals who are related by blood, marriage or adoption
Group health plan	means a plan which meets § 5000(b)(1) of the Internal Revenue Code of 1986, and includes continuation coverage pursuant to Title XXII of the Public Health Service Act, § 4980B of the Internal Revenue Code of 1986, or Title VI of the Employee Retirement Income Security Act of 1974. Section 5000(b)(1) of the Internal Revenue Code provides that a group health plan is 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 such employees or former employees
High Deductible Health Plan	means a health plan as defined under Internal Revenue Code § 223(c)(2)(A) with an annual deductible that for 2009 is not less than \$1,150 for self-only coverage or \$2,300 for family coverage
Participant	means a person who is approved for the HIPP Program
Premium	means that portion of the cost for the group health plan which is the responsibility of the person carrying the group

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I. Right to Apply

An individual cannot be refused the right to complete an application for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An application can be downloaded from the DMAS internet website site at <http://www.dmas.virginia.gov/rcp-HIPP.htm> or by calling the HIPP program at 800-432-5924 (toll free in Virginia or 804-225-4236).

II. Who Can Sign the Application

1. The applicant must be age 18 or older to apply for HIPP. The applicant may be the Medicaid eligible family member, the employee/policy holder and/or the parent/guardian of the Medicaid eligible family member or authorized representative.

2. Applicant not living in the same household

The employee/policyholder can apply for HIPP on behalf of the Medicaid family member(s) not residing in the same household; however, a Consent Form to release information regarding the Medicaid eligibility information must be obtained from the person who filed the application for Medicaid at the Department of Social Services. The applicant is typically shown as the “case name” in the Medicaid information system. The Medicaid applicant must be age 18 or older; therefore, the Consent form must be signed by the parent/guardian of the Medicaid family member under age 18 or by the applicant if age 18 or older.

NOTE: Medicaid eligibility information cannot be provided to someone who is not living in the same household unless consent is granted from the applicant if age 18 or older, or parent/guardian with whom the family member is residing.

III. HIPP Application Forms

1. A HIPP application must be submitted on the form(s) prescribed by DMAS.

A. A complete application for HIPP must be signed and consists of the following:

(1) HIPP Application Form Part 1, and

(2) Employer Insurance Verification Form (EIV) Part-2.

B. The HIPP Application must be signed by either the Employee, Medicaid eligible family member if age 18 or older, or parent/guardian/authorized representative of the Medicaid eligible family member. The Employer Insurance Verification Form must be signed by the Employer Representative or if self employed, by the self employed person.

Note: Retirees who do not have access to a local employer benefit office may complete and sign the Employer Insurance Verification Form in place of the employer. All requested information on the EIV must be completed. If additional information is needed, you will be notified.

2. Place and Date of Application

A. The place of application is the Department of Medical Assistance Services (DMAS).

B. The date of application is the date in which both the HIPP Application Form and EIV are received at DMAS.

C. If the Application Forms Part 1 and Part 2 are not submitted at the same time, the application date is the date in which the last form was received.

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3. Required Documents for Application Evaluation

In order to complete an evaluation for eligibility for the program the following documents must be submitted:

- A. Completed and signed HIPP Application Form Part 1
- B. Completed and signed HIPP Employer Insurance Verification Form (EIV) Part 2
- C. Copy, front and back of all health insurance cards (medical, dental, pharmacy and/or vision)
- D. Copy, front and back of all Insurance Summary of Benefits page(s)
- E. Copy of most recent pay stub showing health insurance premium deduction or if premium is not deducted from pay stub, documentation from employer/insurance company showing the employee's responsibility for the health insurance premium to include a copy of the canceled check or money order supporting payment of the insurance premium
- F. If self employed – most recent completed tax returns to include all attachments and business records, if applicable, in addition to submission of the premium payment documentation requirements noted above.

IV. Application Processing Time Standards

1. Documents required for application evaluation must be provided within 30 calendar days of the application date.
2. Applications will be denied if documents are not received within 30 calendar days.
3. The Department must allow at least 10 calendar days to receive the information requested to process an application.
4. Applications must be processed within 45 calendar days of application date

V. Application Disposition

1. Each application must be disposed of by a finding of Approved or Denied.
2. Applicants must be notified in writing of the finding.
3. Applicants who request withdrawal of application must also be sent written notification the application was denied as the applicant withdrew the application.

IV. Entitlement and Enrollment

1. Approvals
 - A. The applicant will be notified if the application has been approved, including the effective date(s) of enrollment.
 - B. Approval date is the month after the completed application is received or the first day of the month in which the group health plan becomes effective, whichever is later.
2. Denials - The applicant will be notified if the application is denied, including the denial reason

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I. Recipient Eligibility

1. Family member must be enrolled in full coverage Medicaid.
2. Family member must be living in the household as the policy holder of the employer group health plan or provide a Consent Form signed by responsible person and the policy holder authorizing release of Medicaid eligibility information
3. Family member must be enrolled in a comprehensive employer group health insurance plan
4. Health insurance plan must be determined to be cost effective

II. Cost Effectiveness Determination

Cost Effectiveness Determination – the following requirements are evaluated and must be met:

1. Health Insurance Coverage - Health insurance information shall be verified through contact with the employer representative and/or insurance company.
 - A. Medicaid eligible family member must be covered under the health plan.
 - B. Type of coverage
 - a. Health insurance coverage must be comprehensive, (comparable to the Medicaid State Plan coverage) and provide the following services at a minimum:
 - Physican Services
 - In and Out Patient Hospitalization
 - Outpatient labs, shots and x-rays
 - Prescription Drug
 - b. Coverage cannot be a plan that provides a limited benefit such as plans that only provide a maximan payment per day for hospitalization
 - c. COBRA is eligible for evaluation for HIPP
 - C. Medicare coverage - Medicaid eligible family members enrolled in Medicare Part A and/or Part B are not eligible for HIPP.
 - D. Deductibles - annual deductible must be less than the deductible amount as set by Department of Treasury for a High Deductible Health Plan (HDHP). The amount is updated annually by the Department of Treasury. The amount for 2009 is \$1,150 or greater per individual or \$2,300 or greater per family.
 - E. Existing family health coverage-must be an eligible health plan. If the health plan is family coverage (consists of 2 or more family members), evaluate household members covered under the health plan according to the Eligible Family Health Plan Chart. See Appendix 1.
2. Health Insurance Cost Evaluation
 - A. Determine monthly cost of employee share of health insurance premium deduction
 - a. Obtain the monthly premium deduction amount - employee share of cost
 - b. Determine the deduction frequency (weekly, biweekly, etc.) and number of pay periods in the year.
 - c. Multiply the premium deduction amount x frequency of pay period /number of months in year 12 or 10 (some school employees).
Example: Monthly premium deduction is \$50/pay period, pay period frequency is weekly and deductions are taken 52 times.
Calculation is $\$50 \times 52 = \2600 . Monthly premium assistance amount is $\$2600/12 = \216.67 .
 - d. Cost of dental and/or vision premiums are included in the cost evaluation if the Medicaid eligible family member(s) under 21 years of age is covered by the dental/vision plan(s).

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- B. Monthly Medical Cost /HIPP Cost Effectiveness Rate Calculation
 - a. HIPP cost effectiveness rate is calculated for each Medicaid eligible family member.
 - b. The HIPP Rate Chart is used to obtain the Cost Effectiveness Rate (average medical cost) for each Medicaid eligible based on the age, gender, Medicaid enrollment category (individuals receiving long term care services are always evaluated in the Aged, Blind, Disabled group) and geographical region of the state where the family member resides.
 - c. The HIPP cost effectiveness rate for all Medicaid eligible family members is totaled.

C. HIPP Cost Evaluation.

Compare the Monthly Premium Cost in 2A above to the total Monthly Medical Cost/HIPP Cost Effectiveness Rate in 2B above.

- a. If the Monthly Health Insurance Cost is less than Monthly Medical Cost/HIPP Cost Effectiveness Amount, application is cost effective and approved.
- b. If Monthly Health Insurance Cost is not less than Monthly Medical Cost/HIPP Cost Effectiveness Amount, application is not cost effective; DMAS may reimburse and provide premium subsidy up to the lower amount of Monthly Medical Cost/HIPP Cost Effectiveness Amount.

3. Program Requirements Verification

A. The HIPP program must verify all eligibility requirements.

- a. Enrollment in health insurance coverage for Medicaid eligible family member
- b. Health plan covered services and deductibles
- c. Employee cost of employer health insurance

B. The HIPP program will verify eligibility requirements by using documentation submitted by applicant or if information is not available, contact with employer and/or health insurance plan.

III. Application Denials

Applications that do not meet the Program Requirements will be denied.

- I. Participation Requirements. Once an application is approved the participant must continue to meet the eligibility criteria used in the cost effectiveness determination as follows:
1. Participants must remain enrolled in the employer group health plan
 2. Participants must remain Medicaid eligible
 3. Participants must provide on a monthly basis documentation of payment of health insurance premium.
 - A. Monthly submission of documentation showing premium deduction
 - a. Required documentation is a pay stub showing the premium deduction amount
 - b. If the pay stub does not reflect the health insurance deduction, the following documentation can be submitted: a receipt from employer or insurance company along with a copy of the canceled check or money order demonstrating the cost of the insurance has been paid
 - c. Retirees who only receive a statement at the beginning of the year of the health insurance premium amount that will deducted monthly and do not receive a monthly statement need to submit the most current annual statement on a monthly basis. You can make 12 copies, one for each month. Each month you must sign and date the statement. Your signature and date will certify that there are no changes in the health insurance plan or the premium deduction amount(s). Submit a signed copy each month to be received no later than the 1st of each month (see Submission of documentation time frame below).
 - B. Submission of documentation time frame
 - a. Documentation must be submitted by the 1st of each month
 - b. Documentation received after the 10th of each month will not be processed for reimbursement for the current month
 - c. Documentation must reflect a premium payment made in the month prior to the current HIPP payment month. For example, for a reimbursement processed in June the documentation must show that the pay period of the deduction of the health insurance premium was in May with the pay date in May. If the pay period ending is prior to May although payment was issued in May, this would not be considered valid documentation.
 - C. Redeterminations must be completed at least annually
 - a. Redeterminations will be completed during open enrollment period, if the plan has no open enrollment period a redetermination will be completed within 12 months from approval date or last redetermination date
 - b. Typically at open enrollment a participant has the option to change health plans and or elect different coverages. Employers may also change the plans that are available to employees. In addition, costs associated with the plans also change.
 - c. During the open enrollment period, the plan must be reevaluated for cost effectiveness and continued enrollment in HIPP.

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- D. Changes that affect HIPP participation and cost effectiveness must be reported immediately, no later than 10 calendar days from when the participant was aware of the change.
- a. Changes that affect HIPP participation include but are not limited to:
- Family member added or dropped from health insurance plan or dropping health insurance plan completely
 - Change in health insurance plan or health plan coverage
 - Change in employer resulting in change in health insurance plan
 - Change in health plan premium cost
 - Change in employment status (lay off/termination, short-term disability)
 - Address changes
- b. Changes that affect the cost effectiveness evaluation include but are not limited to, new employer, changes in health insurance plans, changes in health plan premium cost, changes in Medicaid eligibility and must be re-evaluated to determine ongoing HIPP participation eligibility

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I. Reimbursement Processing

1. On a monthly basis, the HIPP program verifies continued enrollment in the health care plan by obtaining documentation that the health insurance was paid in the prior month.
2. Premium subsidy reimbursement checks are processed monthly for participants who continue to meet the Program Participation Requirements.
3. Reimbursement checks are issued at the end of the month for the current month's premium cost
4. Reimbursement checks can be issued to either the employee (policy holder), employer or health insurance company

II. School Employees and Other Employees with Seasonal Employment

Participants are reimbursed for the employee cost of the health insurance premium for the month in which the participant has the cost. If there is no premium deduction during a month, there is no reimbursement processed for that month.

1. School Employees working 10 months and get paid only for 10 months receive reimbursement checks for the months in which the premium is deducted. No reimbursement check is issued during the months in which there is no premium.
2. Seasonal Employees and other employees who have irregular pay schedules are only reimbursed the cost of the employee health premium for the month(s) in which the employee has an expense.

III. COBRA (Consolidated Omnibus Budget Reconciliation Act)

Participants covered under COBRA must submit documentation showing that they have enrolled in the COBRA plan and they pay the premium amount.

IV. Payments Not Processed

Payments will not be processed for the following reasons:

1. Documentation of payment of premium cost in the month prior to the payment month not received by the 10th of the payment month
2. Employee has no premium deduction for health insurance cost for the payment month
3. No Medicaid eligible family member is covered under the health insurance plan

V. Payment Suspension

Payments will be suspended for the following reasons:

1. Change reported in employer and/or health insurance plan and cost effectiveness evaluation not completed
2. Change reported in employer and/or health insurance plan and information necessary to perform cost effectiveness evaluation has not been received.

VI. Premium subsidy payment may be reduced or increased during the enrollment year for the following reasons:

1. Family member no longer Medicaid eligible – a family member who is not Medicaid eligible cannot be included in the cost effectiveness evaluation methodology.
2. Change in HIPP rate as a result of an age change at age 1, 6, 15, 21 and 45.
3. Change in Medicaid enrollment category,
4. Change in residence to another region in the Commonwealth.
5. HIPP Cost Effectiveness Rates are adjusted around July of each year.

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VII. Payment Notification Requirements

1. Ten day advance notice is required prior to reducing or suspending payment on a case
2. DMAS is not required to provide advance notice if we do not issue a payment due to nonsubmission of documentation showing payment of premium amount in the month prior to the reimbursement month. DMAS will send notification in the month that the payment would have been made that documentation was not received or not received timely.

- I. Cancellation from HIPP will result for the following reasons:
1. No family member is eligible for Medicaid;
 2. No longer enrolled in health insurance plan as a result of disenrollment from the health plan;
 3. No longer enrolled in health insurance plan as a result of change in employer;
 4. Health plan is no longer cost effective;
 5. Only family member who is Medicaid eligible is enrolled in Medicare Part A and/or Part B;
 6. Failure to submit or complete annual Redeterminations forms and/or provide documentation required to complete Redeterminations;
 7. Failure to provide signed Consent Form when Medicaid eligible family member is not residing in the same household as the policy holder (employee); or
 8. Failure to submit required documentation of incurred health insurance costs (first month payment is suspended, second consecutive month cancellation occurs).

II. Termination Notification Requirements

1. Ten day advance notice is required prior to DMAS cancelling participation in the HIPP program.
2. Notification must provide effective date and cite the reason for cancellation.

III. Appeal Rights

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce premium assistance,
- fails to take an application for premium assistance,
- fails to act on an application for premium assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of premium assistance.

A. Notification and Rights

At the time of application or redeterminations, and at the time of any action or proposed action affecting payment of premium assistance, the applicant for and participant of premium assistance shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesperson.

B. Appeal Request Procedures

An appeal is a request for a fair hearing. The request must be a clear, written expression by an applicant or enrollee, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."

C. Where to File an Appeal

Appeals must be sent to the:

Department of Medical Assistance Services
Appeals Division, 11th Floor
600 East Broad Street
Richmond, Virginia 23219
Appeals may also be faxed to (804) 371-8491.

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D. Appeal Time Standards

A request for an appeal must be made within 30 days of receipt of notification that premium assistance has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/participant within three days of the date the notice was mailed, unless the applicant/participant substantiates that the notice was not received in the three-day period through no fault of his/her own.

An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:

- the postmark date,
- the date of an internal DMAS receipt date-stamp, or
- the date the request was faxed or hand-delivered.

In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day. DMAS will, at its discretion, grant an extension of the time limit for requesting an appeal if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

INELIGIBLE FAMILY PLAN

Employee		Spouse		Medicaid Family Member	NonMedicaid Family Member	Eligible Plan
Medicaid Enrolled	NotMedicaid Enrolled	Medicaid Enrolled	NotMedicaid Enrolled			Y/N
	X		X	1 or more	1 or more	No
	X	0	0	1 or more	2 or more	No
	X	X		1 or more	2 or more	No
X		X		1 or more	2 or more	No
X		X		0	2 or more	No
X			X	0	1 or more	No
X		0	0	1 only	2 or more	No
X		0	0	2 or more	2 or more	No

ELIGIBLE FAMILY PLAN

Employee		Spouse		Medicaid Family Member	NonMedicaid Family Member	Eligible Plan
Medicaid Enrolled	NotMedicaid Enrolled	Medicaid Enrolled	NotMedicaid Enrolled			Y/N
	X	X		0	0	Yes
	X	X		1 or more	0	Yes
	X	X		1 only	1 only	Yes
	X	X		2 or more	1 only	Yes
	X		X	1 or more	0	Yes
	X	0	0	1 or more	0	Yes
	X	0	0	1 or more	1 only	Yes
X		X		0	0	Yes
X		X		0	1 only	Yes
X		X		1 or more	0	Yes
X		X		1 only	1 only	Yes
X			X	1 or more	0	Yes
X		0	0	1 or more	0	Yes
X		0	0	1 or more	1 only	Yes

Virginia Medicaid

FY 2010 HIPP Cost Effectiveness Rates

Additional \$10 has been included in rates for age under 21 for Dental Insurance
 Rates Effective August 1, 2009

Aged, Blind and Disabled					
	Region				
Age Group	Northern Virginia Region 0010	Other MSA Region 0011	Richmond/Charlottesville Region 0012	Rural Region 0013	Tidewater Region 0014
Under 1	\$2,725.96	\$2,725.96	\$2,725.96	\$2,725.96	\$2,725.96
1-5	\$964.06	\$1,056.48	\$733.56	\$699.61	\$857.01
6-14	\$635.19	\$397.91	\$373.45	\$453.33	\$415.82
Female 15-20	\$635.19	\$397.91	\$373.45	\$453.33	\$415.82
Female 21-44	\$1,048.09	\$899.92	\$1,000.51	\$905.63	\$871.62
Male 15-20	\$635.19	\$397.91	\$373.45	\$453.33	\$415.82
Male 21-44	\$884.62	\$694.92	\$801.19	\$716.97	\$773.46
Over 44	\$1,091.59	\$1,145.21	\$1,304.61	\$1,120.80	\$1,246.08

Families and Children					
Under 1	\$376.23	\$460.32	\$513.31	\$522.73	\$532.44
1-5	\$132.14	\$122.00	\$143.65	\$131.51	\$130.07
6-14	\$112.39	\$112.76	\$112.14	\$118.09	\$112.74
Female 15-20	\$226.65	\$305.64	\$251.11	\$282.97	\$243.18
Female 21-44	\$506.96	\$502.14	\$449.74	\$522.07	\$419.56
Male 15-20	\$112.56	\$138.98	\$126.62	\$134.52	\$138.63
Male 21-44	\$308.30	\$378.02	\$283.00	\$412.55	\$326.71
Over 44	\$589.93	\$606.82	\$542.21	\$633.61	\$607.78

HIPP REGIONS

REGION 0010 - NOVA	
FIPS	CITY/COUNTY
013	Arlington
043	Clarke
047	Culpeper
059	Fairfax
061	Fauquier
099	King George
107	Loudon
153	Prince William
177	Spotsylvania
179	Stafford
187	Warren
510	Alexandria
600	Fairfax
610	Falls Church
630	Fredericksburg
683	Manassas
685	Manassas Park

REGION 0011 - OTHER MSA	
FIPS	CITY/COUNTY
019	Bedford
023	Botetourt
031	Campbell
143	Pittsylvania
161	Roanoke
169	Scott
191	Washington
515	Bedford
520	Bristol
590	Danville
680	Lynchburg
770	Roanoke

REGION 0012 - RICH/CH	
FIPS	CITY/COUNTY
003	Albemarle
036	Charles City
041	Chesterfield
053	Dinwiddie
065	Fluvanna
075	Goochland
079	Greene
085	Hanover
087	Henrico
127	New Kent
145	Powhatan
149	Prince George
540	Charlottesville
570	Colonial Heights
670	Hopewell
730	Petersburg
760	Richmond

REGION 0014- TIDEWATER	
FIPS	CITY/COUNTY
073	Gloucester
093	Isle Of Wight
095	James City
115	Mathews
199	York
550	Chesapeake
650	Hampton
700	Newport News
710	Norfolk
735	Poquoson
740	Portsmouth
800	Suffolk
810	Virginia Beach
830	Williamsburg

Region 0013 - Rural

FIPS	City/County	FIPS	City/County	FIPS	City/County	FIPS	City/County
001	Accomack	069	Frederick	135	Nottoway	530	Buena Vista
005	Alleghany	071	Giles	137	Orange	560	Clifton Forge
007	Amelia	077	Grayson	139	Page	580	Covington
009	Amherst	081	Greensville	141	Patrick	595	Emporia
011	Appomattox	083	Halifax	147	Prince Edward	620	Franklin
015	Augusta	089	Henry	155	Pulaski	640	Galax
017	Bath	091	Highland	157	Rappahannock	660	Harrisonburg
021	Bland	097	King And Queen	159	Richmond Co.	678	Lexington
025	Brunswick	101	King William	163	Rockbridge	690	Martinsville
027	Buchanan	103	Lancaster	165	Rockingham	720	Norton
029	Buckingham	105	Lee	167	Russell	750	Radford
033	Caroline	109	Louisa	171	Shenandoah	780	South Boston
035	Carroll	111	Lunenburg	173	Smyth	790	Staunton
037	Charlotte	113	Madison	175	Southampton	820	Waynesboro
045	Craig	117	Mecklenburg	181	Surry	840	Winchester
049	Cumberland	119	Middlesex	183	Sussex		
051	Dickenson	121	Montgomery	185	Tazewell		
057	Essex	125	Nelson	193	Westmoreland		
063	Floyd	131	Northampton	195	Wise		
067	Franklin	133	Northumberland	197	Wythe		

INSTRUCTIONS FOR COMPLETING THE HEALTH INSURANCE PREMIUM PAYMENT (HIPP) APPLICATION - PART 1 OF 2

Instructions: Please print and answer all of the questions, then sign and date the HIPP Program Application – Part 1. Attach a copy (front and back) of all health insurance cards (Medical, Dental & Pharmacy), copy of your latest pay stub and a copy of the Summary of Benefits (this is a summary of what is covered under the insurance plan) to your HIPP Program Application - Part 1, along with a completed Employer Insurance Verification Form – Part 2. Mail all documents to the HIPP Unit address listed below.

Section 1 – Personal Information

Provide the Employee's full name, telephone numbers to include the area code, complete street address and mailing address (if different), city, state, zip code. If a home, work or cellular number is not available, please include an alternate number where a message can be left.

If the enrollee's address is different from the policyholder's, please provide complete street address, city, state and zip code.

Section 2 – Household Information

Starting with the employed person, list all household members including, but not limited to, parents, step-parents, guardians and children. Complete the date of birth in month/day/year format for each household member. Indicate the relationship of the person to the employed person by circling the corresponding number and relationship; i.e., 1 - Spouse, 2 – Parent/Step, 3 – Child, 4 –Step-child, 5 –Guardian, Other (specify).

Next, enter the nine-digit Social Security Number for each household member. Answer the remaining questions for each household member by placing a checkmark or an 'x' in the appropriate box.

Section 3 – Employer/Company Information

Indicate whether employment status is full or part-time and the date hired. If retired from previous employment, please indicate as well. Provide the employer or company name, street address, city, state and zip code, as well as the Human Resource Representative, or Benefits Manager's name and work phone number. If none, please provide a work phone number.

Indicate by placing a checkmark or an 'x' in the appropriate box, if the Policyholder's health insurance is covered under an Employer Sponsored plan, COBRA, or Individual Policy. If the Individual Policy box is selected, indicate whether the Policyholder is self-employed.

Indicate whether the health insurance premium is taken from the Policyholder's paycheck weekly, every two weeks, 24 times a year, 26 times a year, semi-monthly or monthly. If none of the choices apply, please select 'not applicable'. Indicate the amount taken from each pay period.

Indicate whether the Policyholder is able to enroll Medicaid eligible household members not currently enrolled under the employer or COBRA plan. Enter the earliest enrollment date in month/day/year format.

Please read the authorization section carefully and sign the HIPP Program Application - Part 1. Attach a copy (front and back) of all health insurance cards (Medical, Dental & Pharmacy), copy of your latest pay stub and a copy of the Summary of Benefits (this is a summary of what is covered under the insurance plan) to your HIPP Program Application – Part 1 and completed Employer Insurance Verification Form – Part 2. **Both the HIPP Program Application – Part 1 and Employer Insurance Verification Form – Part 2 must be received to be considered an application. The application date will be the date of when both forms are received by DMAS.** Mail all documents to the HIPP Unit address listed below.

Virginia Department of Medical Assistance Services
Health Insurance Premium Payment (HIPP) Program
600 E. Broad Street, 12th Floor
Richmond, VA 23219
(804) 225-4236 / (800) 432-5924 (in Virginia only)



**Virginia Department of Medical Assistance Services
Health Insurance Premium Payment (HIPP) Program Application - Part 1 of 2
600 E. Broad Street, 12th Floor, Richmond, VA 23219
(804) 225-4236 / (800) 432-5924 (in Virginia only)**

SECTION 1: PERSONAL INFORMATION

(Last, First, MI) Policyholder/Employee Name:

Home Phone ()	Cell Phone ()	Work Phone ()	Alternate Phone: ()	
Street Address:		City	State	Zip Code
Mailing Address (if different):		City	State	Zip Code

PLEASE PROVIDE ENROLLEE'S ADDRESS IF DIFFERENT FROM POLICYHOLDER'S:

Street Address: _____ City: _____ State: _____ Zip Code: _____

SECTION 2: HOUSEHOLD INFORMATION (PLEASE PRINT) - STARTING WITH THE POLICYHOLDER, LIST EVERYONE LIVING IN THE HOUSEHOLD

Name (Last, First MI)	Date of Birth (MM/DD/YY)	Relationship to Policyholder/Employee? 1 - Spouse 2 - Parent/Step 3 - Child 4 - Step-child 5 - Guardian Other (Specify)	Social Security Number	Does this person get Medicaid?	Does this person get Medicare?	Is this person covered under your insurance?
	/ /	Policyholder/Employee	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	/ /	1 2 3 4 5 Other: _____	- -	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3: EMPLOYER/COMPANY INFORMATION

Employee Status: Full-Time Part-Time
 Date Hired: _____
 Retired from previous employment? Yes No

Human Resources Representative or Benefits Manager: _____
 Representative's Phone Number: () _____

Name of Employer/Company and Street Address: _____
 City: _____ State: _____ Zip Code: _____

Insurance Plan Type: Employer Plan COBRA Individual Policy None
 If Individual Policy, is the Policyholder self employed? Yes No Not Applicable

How often do you pay the insurance premium? Weekly Every Two Weeks: 24/year, **or** 26/year
 Semi-Monthly Monthly Other: _____
 Amount Each Pay Period: \$ _____

Can you enroll Medicaid family members under your employer or COBRA health plan, if not currently enrolled?
 Yes No Not Applicable If yes, what is the earliest date (MM/DD/YY)? _____

AUTHORIZATION: "My signature below certifies under penalty of perjury that all declarations made in this application are true, accurate and complete, to the best of my knowledge. I authorize insurers or employers to release any information on myself, or other household member (s) necessary to determine eligibility for the HIPP Program."

Signature of Applicant _____ (MM/DD/YY)
 Date: _____

SECTION 4: HIPP SECTION ONLY

Medicaid Case ID #:	Medicaid Case Name:	HIPP #:	Court Ordered Absent Parent Case? <input type="checkbox"/> Yes <input type="checkbox"/> No	Analyst's Initials:
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EMPLOYER INSURANCE VERIFICATION



Virginia Department of Medical Assistance Services
 Health Insurance Premium Payment (HIPP) Program Application – Part 2
 600 E. Broad Street, 12th Floor, Richmond, VA 23219
 (804) 225-4236 / (800) 432-5924 (in Virginia only)

The Commonwealth of Virginia is considering providing the health insurance premium assistance on behalf of the employee below, in accordance with Section 1906 of the Social Security Act. Any information provided on the form will remain confidential. In order to make a determination, please complete and return this form within 15 days to the mailing address above. If you have questions in regards to completing the form, please contact us at the phone numbers listed above.

My signature serves as a release of information for verification of all required information.

Employee Name: _____ Phone Number: _____

Address: _____ Signature: _____ Date: _____

INFORMATION BELOW IS TO BE COMPLETED BY THE EMPLOYER ONLY
If self-employed the policyholder must complete as the employer.

SECTION 1 – EMPLOYEE INFORMATION

Employee Name (Last, First, MI):	Full SSN: - -	(MM/DD/YY) Date of Birth: / /
1a. Employee Status <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time Date Hired: _____	1c. Is this employee eligible for coverage under your company's group health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", reason: _____)	
1b. Retired from previous employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	1d. Is employee currently enrolled in the Health Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide the Effective Date: _____	

SECTION 2 – MEMBERSHIP (Starting with Employee) - Attach an additional page if more than 7

Name (Last, First MI)	Full SSN	Date of Birth	Relationship	Currently Enrolled in Plan	Eligible for Health Plan
	- -	/ /	Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	- -	/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3 - COVERAGE

OPEN-ENROLLMENT INFORMATION

3a. If the employee is currently enrolled, what is the type of coverage? Select one of the following:

- Employee Only Employee + Child Family
 Employee + Spouse Employee + Children Other _____
 COBRA

3b. Effective Date (MM/DD/YY): ____/____/____

Open Enrollment Dates

From: _____ To: _____

3c. If the employee is not currently enrolled, when can enrollment occur?

- During Open Enrollment Dates: _____ After employment period is met - Date Eligible: _____
 Anytime

SECTION 4 – PLAN BENEFITS (Please indicate the cost and benefits for the coverage you have selected.)

Employee Name (Last, First, MI):	Full SSN: - -
Medical/Health: Name and Address of Insurance Company: Insurance Company Phone: () Insurance Policy/Group Number:	Dental (if Applicable): Name and Address of Insurance Company: Insurance Company Phone: () Insurance Policy/Group Number:
Does policy have a health savings account (HSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No What are the yearly deductibles for the health insurance: Individual \$ Family \$	Vision (if Applicable): Name and Address of Insurance Company: Insurance Company Phone: () Insurance Policy/Group Number:

Type of Health Plan (Check all that apply): <input type="checkbox"/> Comprehensive Major Medical <input type="checkbox"/> HMO/PPO <input type="checkbox"/> Hospital Only <input type="checkbox"/> Dental <input type="checkbox"/> High Deductible Health Plan <input type="checkbox"/> Other (please explain):	Services Covered Under the Health Plan (Check all that apply): <input type="checkbox"/> Medical <input type="checkbox"/> Pharmacy <input type="checkbox"/> Vision <input type="checkbox"/> Dental
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Medical/Health, Dental and Vision Insurance Premium Information. (Employee's cost for the plans selected)

Coverage	Medical/Health Premium	Dental Premium	Vision Premium	Medical/Health Premium	Dental Premium	Vision Premium
Employee Only	\$	\$	\$			
Employee + Spouse	\$	\$	\$	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks: <input type="checkbox"/> 24/year <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks: <input type="checkbox"/> 24/year <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Other: _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks: <input type="checkbox"/> 24/year <input type="checkbox"/> 26/year <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly Other: _____
Employee + Child	\$	\$	\$			
Employee + Children	\$	\$	\$			
Family	\$	\$	\$			
Other	\$	\$	\$			

SECTION 5 – EMPLOYER'S REPRESENTATIVE

Human Resource Representative or Benefits Manager:	Department:		
Employer/Company Name:	Work Phone: ()		
Employer Address:	City:	State:	Zip Code:

Health Insurance Premium Payment (HIPP) Program

**CONSENT FOR AUTHORIZATION FOR RELEASE OF INFORMATION
FAMILY MEMBER ELIGIBILITY RELEASE**

Purpose: Authorization for release of Medicaid eligibility information is required by the HIPP program when the Medicaid eligible family member who is enrolled in the health insurance plan is not living in the same household as the policyholder who has the insurance coverage. Medicaid eligibility is required for HIPP participation. Therefore, it may be necessary for the HIPP program to communicate information regarding the eligibility status of a family member to the policy holder who is not living in the same household.

This consent form must be signed either by the Medicaid eligible family member if age 18 or older, or by the parent/guardian of the Medicaid family member(s) under the age of 18. If the consent form is not signed authorizing release of Medicaid eligibility information, participation in the HIPP program will be denied.

This authorization will remain in effect as long as there is continuous participation in the HIPP program. Any break in participation will require a new signed consent form.

I authorize the HIPP program to release information regarding my or my family member(s) Medicaid eligibility to _____(policy holder name) for the purpose of participation in the HIPP program.

(Print Name: Last, First, MI)

Date

Signature

Phone Number

Relationship to Medicaid Family Member
(Self/Parent/Guardian)

Health Insurance Premium Payment (HIPP) Program

CONSENT FOR AUTHORIZATION FOR RELEASE OF INFORMATION POLICYHOLDER HEALTH INSURANCE COVERAGE RELEASE

Purpose: Authorization for release of health insurance coverage information is required by the HIPP program when the Medicaid eligible family member who is enrolled in the health insurance plan is not living in the same household as the policyholder who has the insurance coverage. It may be necessary for the HIPP program to communicate information regarding the health insurance coverage to the Medicaid eligible family member(s) who are not living in the same household. Therefore, this consent form provides authorization to release information about the health insurance coverage to the Medicaid eligible family member(s) or parent/guardian of the Medicaid member if under age 18, as it relates to participation in the HIPP program.

This consent form must be signed by the policyholder of the health insurance coverage. If the consent form is not signed authorizing release of Medicaid eligibility information, participation in the HIPP program will be denied.

This authorization will remain in effect as long as there is continuous participation in the HIPP program. Any break in participation will require a new signed consent form.

I authorize the HIPP program to release information regarding the health insurance coverage for my Medicaid eligible family member(s) who are not living in my household that is related to participation in the HIPP program.

(Print Name: Last, First MI)

Date

Policyholder Signature

Phone Number