# H-3900 Louisiana Health Insurance Premium Payment Program (LaHIPP)

## H-3901 General Information

The Louisiana Health Insurance Premium Payment (LaHIPP) program is a Medicaid benefit that helps individuals and families pay for employer-sponsored insurance (ESI) or Individual Health Insurance (IHI) when it is cost-effective for Medicaid. The program enables eligible individuals and their families to maintain private health coverage while reducing Medicaid program costs.

LaHIPP may reimburse premiums for the policyholder and Medicaid eligible family members who are enrolled or have access to employer-sponsored health insurance or Individual Health Insurance (IHI) when it is determined that the cost of premiums is less than the projected Medicaid expenditures.

LaHIPP enrollment requires a determination that pays the employer-sponsored insurance premium or individual health insurance (IHI) is cost-effective.

An applicant/beneficiary may qualify for LaHIPP if:

- The employee is Medicaid eligible or have a family member who is Medicaid eligible; and
- The individual must be enrolled or have access to employer-sponsored or individual health insurance coverage; and
- The coverage must be determined cost-effective by the Louisiana Department of Health (LDH).

The following individuals do not qualify for LaHIPP:

- Individuals enrolled in spenddown;
- Medicaid beneficiaries entitled to Medicare Part B, but refuse to enroll;
- Long-Term Care (excluding TEFRA), Waiver, Chisolm and CSoC beneficiaries;
- Persons with only Hospital Indemnity Insurance;
- Persons with single scope of coverage insurance, such as dental or vision insurance under a separate premium;
- A self-employed individual, unless this individual offers insurance to employees in his company or
- A child receiving court ordered medical support

## H-3902 Coverage

The LaHIPP Program is a premium assistance program, not a separate Medicaid coverage group. Participation in LaHIPP does not establish Medicaid, affect eligibility, or provide independent Medicaid coverage and is not considered creditable coverage. Eligible individuals remain enrolled in their existing coverage group.

A LaCHIP or BCC applicant/beneficiary may have insurance coverage if purchased through the LaHIPP program. If Medicaid is reimbursing the premium through LaHIPP, this coverage is not considered creditable health insurance and does not impact LaCHIP or BCC eligibility.

LaHIPP reimburses the cost of employer-sponsored or individual health insurance premiums for the policyholder and Medicaid-eligible dependents when coverage is determined to be cost-effective.

Medicaid covers insurance co-payments and deductible if the beneficiary's provider is in the health insurance plan's network and accepts Medicaid as a secondary payer, and the beneficiary follows all plan guidelines. If an individual covered on the health insurance policy is not a Medicaid beneficiary, they are responsible for their own copays, coinsurance and deductibles.

## H-3903 Eligibility Determination Process

LaHIPP Eligibility Advisors are responsible for making the eligibility determination.

## H-3904 Cost-Effectiveness

Cost-effectiveness means the total amount the state pays for premiums and required cost-sharing is less than what it would cost Medicaid to provide the same services directly. The Louisiana Department of Health (LDH) determines cost-effectiveness using established methodology and projected Medicaid expenditures.

Cost-Effective Methodology

1. To determine the total cost of ESI/IHI participation, add the following:

    - Annual Premium Cost
    - Deductible
        - If enrolled 12 months or more, use actual deduction
        - If enrolled less than 12 months, calculate 60%

- Copay Wrap Costs
- Administrative Costs
- Benefits Wrap Costs

2. The Medicaid amount is either:

   - The Per Month Per Member (PMPM**)** rate if the member is in an Managed Care Organization (MCO) or
   - The FFS claims cost if the member is in Fee-for-Service (FFS) (excluding waiver services)

3. The case is cost-effective when the Medicaid amount is higher than the total cost of ESI/IHI participation.

## H-3905 Renewals

Renewal is the process of verifying that the beneficiary continues to meet all eligibility factors of the program. Periodical reviews are conducted to ensure cost-effectiveness to ensure continued eligibility and fiscal benefit to the Medicaid program.

Renewal packets are sent 30 Calendar days prior to the first Calendar Day of the policyholder's Open Enrollment and process renewals prior to the end of the policyholder's Open Enrollment.

## H-3906 Changes

Participants are required to report the following changes within 10 days:

- Changes in employment status or access to insurance;
- Changes in premium amount or policy coverage; and
- Termination of employer-sponsored insurance.

Failure to report changes may result in termination of LaHIPP participation or overpayment recovery.

A cost-effectiveness review is required when any of the following occur during the eligibility period.

- Change in employment or access to employer-sponsored coverage.
- Change in premium amount, cost-sharing, or insurance plan benefits.
- Change in household composition or Medicaid eligibility status.
- Change in projected Medicaid expenditures that affects the cost-effectiveness calculation.

## H-3907 Eligibility Period

LaHIPP eligibility follows the individual's insurance enrollment period.

LaHIPP participation will be terminated when:

- The coverage is no longer cost-effective;
- The Medicaid eligibility of the covered individual ends;
- The employer-sponsored insurance ends or becomes unavailable;
- The participant fails to submit the documentation needed to meet program requirements;
- The primary holder moves out of state or
- The primary holder dies.

## H-3908 Securing Information to Determine Eligibility

Secure essential information for determining eligibility. Only require the applicant to provide information that cannot be obtained from other data sources and is necessary to make an eligibility determination or for purposes directly connected to the administration of the Medicaid State Plan.

If the applicant cannot furnish all of the required verifications at the time of application, send a missing information request that contains a list of the items or actions needed, with the deadline for submission specified. Allow at least ten (10) calendar days for an applicant/beneficiary to provide the requested verifications for applications and changes.

Allow at least thirty (30) calendar days for a beneficiary to provide the requested verifications for a renewal and change.

## H-3909 Notice of Decision

LaHIPP Eligibility Advisors will issue a decision notice.

## H-3910 Fair Hearing

Refer to T-100 GENERAL INFORMATION