Virginia Regulatory Town Hall

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Proposed Regulation
Agency Background Document

Agency name	Department of Medical Assistance Services
Virginia Administrative Code (VAC) citation	12 VAC 30-20-210
Regulation title	Administration of Medical Assistance Services: State method on cost effectiveness of employer-based group health plans – individual and family plans
Action title	HIPP Cost Effectiveness Methodology
Document preparation date	

This information is required for executive branch review and the Virginia Registrar of Regulations, pursuant to the Virginia Administrative Process Act (APA), Executive Orders 36 (2006) and 58 (1999), and the *Virginia Register Form, Style, and Procedure Manual.*

Brief summary

In a short paragraph, please summarize all substantive provisions of new regulations or changes to existing regulations that are being proposed in this regulatory action.

Chapter 781, Item 306 AAA of the 2009 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to amend the State Plan for Medical Assistance to clarify that existing family healthcare coverage is a factor in the determination of eligibility under the Health Insurance Premium Payment program (HIPP). Cases which result in a determination that participation is denied based upon the existence of family health care coverage shall be denied premium assistance. This action is intended to satisfy that mandate.

Acronyms and Definitions

Please define all acronyms used in the Agency Background Document. Also, please define any technical terms that are used in the document that are not also defined in the "Definition" section of the regulations.

HIPP means the Health Insurance Premium Payment program.
DMAS means the Department of Medical Assistance Services
DSS means the Department of Social Services
HDHP means High Deductible Health Plan

Legal basis

Please identify the state and/or federal legal authority to promulgate this proposed regulation, including (1) the most relevant law and/or regulation, including Code of Virginia citation and General Assembly chapter number(s), if applicable, and (2) promulgating entity, i.e., the agency, board or person. Describe the legal authority and the extent to which the authority is mandatory or discretionary.

The *Code of Virginia* (1950) as amended, § 32.1-325, grants to the Board of Medical Assistance Services the authority to administer and amend the Plan for Medical Assistance. The *Code of Virginia* (1950) as amended, § 32.1-324, authorizes the Director of DMAS to administer and amend the Plan for Medical Assistance according to the Board's requirements. The Medicaid authority as established by § 1902 (a) of the *Social Security Act* [42 U.S.C. 1396a] provides governing authority for payments for services.

Purpose

Please explain the need for the new or amended regulation by (1) detailing the specific reasons why this regulatory action is essential to protect the health, safety, or welfare of citizens, and (2) discussing the goals of the proposal, the environmental benefits, and the problems the proposal is intended to solve.

This regulatory action is intended to clarify that the HIPP eligibility evaluation includes whether family healthcare coverage exists at the time that HIPP participation is evaluated, regardless of whether the eligibility evaluation is at the time of initial application or during a re-evaluation. Upon implementation of this change, having existing family health care coverage will be considered in the HIPP eligibility determination. This change will require the amendment of regulations addressing HIPP eligibility, family healthcare coverage, and a clarification of the cost-effectiveness methodology. These changes are needed to ensure that HIPP payments made for the participants enrolled in the HIPP program are overall cost effective for the State.

Substance

Please briefly identify and explain new substantive provisions (for new regulations), substantive changes to existing sections or both where appropriate. (More detail about all provisions or changes is requested in the "Detail of changes" section.)

The Medicaid State Plan section affected by this regulatory action is State method on cost effectiveness of employer-based group health plans (12 VAC 30-20-210).

When the HIPP program was enacted in 1991 by the federal government it was envisioned as a means to reduce the cost of the Medicaid program by shifting the cost of medical expenses onto the employer health plan if one was available. The HIPP regulations require a cost effectiveness determination of the employer health plan for enrollment. Cost effectiveness is defined as meaning that it is likely to cost the state less to pay the employee's share of the health insurance

premium and any cost sharing items for the Medicaid eligible household members, than it would cost otherwise under Medicaid. As a result of Medicaid eligibility rules, there are circumstances that allow a family member(s) to be evaluated for Medicaid without evaluating family income. Eligibility is based on the individual's income only. These Medicaid enrollees whose eligibility is not determined based on family household income are likely to be covered under a family health insurance policy which includes family members not enrolled in Medicaid. Under the current changes being made in this regulation, a family that would have family health coverage for three or more members not enrolled in Medicaid would not be eligible for the HIPP program. The family would have the family coverage regardless if there a family member enrolled in Medicaid; therefore, the Commonwealth will no longer enroll Medicaid recipients in HIPP who would otherwise remain enrolled in the family health insurance if HIPP were not available.

High deductible health plans (HDHPs) are not cost effective for the HIPP program. In recent years as a result of increased insurance costs, many health care plans have adopted "high deductible" plans. An HDHP is defined in section 232(c)(2) of the Internal Revenue Code of 1986. The Department of Treasury updates the deductible amounts on an annual basis. These plans were nonexistent at the inception of the HIPP program; however, they have become more prevalent in recent years as health insurance premiums have increased. Medicaid would be paying all medical expenses until the deductible is met as well as the monthly premium. Because Medicaid eligibility only exists on a month to month basis, HDHPs are not cost effective for the HIPP program. Inclusion of this language provides clarity to the process that is currently followed today and is consistent with current federal regulations. The Child Health Insurance Program Reauthorization Action of 2009 included additional options for Premium Assistance Program under 1906A of the Social Security Action and specifically excludes HDHP coverage for consideration.

Program participation requirements have been defined to ensure participants initially found eligible continue to meet the cost effectiveness requirements. Additionally, program termination reasons have been included in the regulations. Current regulations provided reasons for terminating payments; however, nothing was defined regarding termination from the program. Including termination reasons provides clear authority to terminate participation in the program when participation requirements are not met. These regulations respond to the General Assembly mandate clarifying several aspects of the HIPP cost effectiveness methodology, including promulgating several new definitions and addressing family healthcare issues with regard to HIPP.

Current regulations provided a clause for consideration for extraordinary circumstances of some recipients who are not eligible for HIPP. This language was removed because these eligibles are not cost effective for the HIPP program as they have limited eligibility, reside in a nursing home or are Medicare eligible. Revisions were made to clarify that premium assistance subsidies begin the month after a completed application is received rather than at the time the cost effectiveness determination is made. This change reflects the current methodology used.

Language was revised regarding the submission of documentation required for premium assistance subsidy reimbursement. The HIPP program became an optional program effective July 23, 2009; participation in HIPP is no longer a condition for Medicaid eligibility. Language

regarding DSS receiving the required premium documentation has been removed from the regulation as the information is to be submitted directly to DMAS.

Please note: At the time of the emergency regulation promulgated as a precursor to this proposed regulation, 12 VAC 30-20-210 was also the subject of a fast-track regulatory action. Due to the difficulties of effecting changes in this section at the time another action is taking effect in the same regulatory subsection, DMAS elected to make the emergency changes both in 21 VAC 30-20-210 and in a new mirror image subsection, 12 VAC 30-20-211. The changes of the text in 12 VAC 30-20-210 made in the fast-track regulation are now final, and there is no further need to have two separate regulatory sections to address the current changes in 12 VAC 30-20-210. DMAS is therefore inserting all the emergency changes from 12 VAC 30-20-211 into 12 VAC 20-30-210 in this proposed regulation. This will leave 12 VAC 30-20-210 as the only regulatory subsection in this action going forward to the proposed and final stages.

Please also note: DMAS noted in the published emergency regulation background document that the Agency intended to address several other issues in this proposed and later final regulations that follow the prior emergency action. Therefore, please note that the Agency is modifying 12 VAC 30-20-210 to address several issues pertinent to the HIPP program, but which are not part of Chapter 781, Item 306 AAA of the 2009 Appropriation Act. These issues include, but are not limited to, requirements regarding consent forms in the HIPP program, termination from the program, and program eligibility and participation requirements.

Issues

Please identify the issues associated with the proposed regulatory action, including:
1) the primary advantages and disadvantages to the public, such as individual private citizens or businesses, of implementing the new or amended provisions;
2) the primary advantages and disadvantages to the agency or the Commonwealth; and
3) other pertinent matters of interest to the regulated community, government officials, and the public.
If the regulatory action poses no disadvantages to the public or the Commonwealth, please so indicate.

The primary disadvantage of this regulatory action for the public is that the families that were enrolled in HIPP with family coverage have been canceled and new applications with existing family health insurance are being denied. The families were accustomed to receiving reimbursement for the cost of the health insurance plan and these funds have now been discontinued. However, these participants incurred the cost of the insurance prior to applying to the HIPP program. The intent of the HIPP program is to provide for premium assistance for an employer group health insurance plan when the Medicaid recipient otherwise would not be enrolled in the group health plan. The families impacted by this regulatory change are already enrolled in their employer group health plan and most likely will continue to be enrolled in their employer group health plan for the family members who are not enrolled in Medicaid regardless of whether they participated in HIPP or not. Although through this program there has been a cost savings for individual policy holders and their families, the purpose of the program is a cost savings measure for the Commonwealth. Removing these families from the HIPP program does not mean that an enrollee's Medicaid eligibility is lost. Recipients who remain otherwise eligible for Medicaid continue their Medicaid coverage.

The primary advantage to the Commonwealth is cost savings by ensuring that the HIPP program provides for premium assistance as appropriate by not enrolling participants who would otherwise be covered under private insurance. The HIPP program is intended to be an overall cost savings program for the Commonwealth. Medicaid enrollment has changed over the years with the inclusion of additional covered groups in which family income is not evaluated only the individual's income is taken into consideration, while the HIPP program regulations have not been revised to reflect these eligibility changes. The HIPP program was intended to provide premium assistance for Medicaid eligibles enrollment in their employer group health when they would otherwise not be enrolled without being in the HIPP program. The HIPP program was not intended to provide premium assistance for families who would have family coverage for the household members who are not enrolled in Medicaid. Participants being denied HIPP participation under this regulatory change are dissatisfied with this change; however, in most instances they were in HIPP when only one family member was enrolled in Medicaid. These current regulatory changes do not permit HIPP enrollment with family employer policies where three or more insured family members are non-Medicaid recipients.

Requirements more restrictive than federal

Please identify and describe any requirement of the proposal, which are more restrictive than applicable federal requirements. Include a rationale for the need for the more restrictive requirements. If there are no applicable federal requirements or no requirements that exceed applicable federal requirements, include a statement to that effect.

These changes are not more restrictive than any federal requirement.

Localities particularly affected

Please identify any locality particularly affected by the proposed regulation. Locality particularly affected means any locality which bears any identified disproportionate material impact which would not be experienced by other localities.

There are no localities particularly affected, as the regulations apply statewide.

Public participation

Please include a statement that in addition to any other comments on the proposal, the agency is seeking comments on the costs and benefits of the proposal and the impacts of the regulated community.

DMAS is seeking comments on the intended regulatory action, including but not limited to 1) ideas to assist in the development of a proposal, 2) the costs and benefits of the alternatives stated in this background document or other alternatives and 3) potential impacts of the regulation. DMAS is also seeking information on impacts on small businesses as defined in § 2.2-4007.1 of the Code of Virginia. Information may include 1) projected reporting,

recordkeeping and other administrative costs, 2) probable effect of the regulation on small businesses, and 3) description of less intrusive or costly alternative methods of achieving the purpose of the regulation. Anyone wishing to submit written comments for the public comment file may do so by mail, email or fax to Carol Cartte, Dept. of Medical Asst. Services, 600 East Broad St., Richmond, Virginia, 23219. (804) 786-0690, Fax: (804) 786-0690. **Carol.Cartte@dmas.virginia.gov**

Written comments must include the name and address of the commenter. In order to be considered comments must be received by the last day of the public comment period. A public meeting will not be held pursuant to an authorization to proceed without holding a public meeting.

Economic impact

Please identify the anticipated economic impact of the proposed new regulations or amendments to the existing regulation. When describing a particular economic impact, please specify which new requirement or change in requirement creates the anticipated economic impact.

Projected cost to the state to implement and enforce the proposed regulation, including (a) fund source, and (b) a delineation of one-time versus on-going expenditures.	There are no additional costs associated with this action.
Projected cost of the *new regulations or changes to existing regulations* on localities.	None
Description of the individuals, businesses or other entities likely to be affected by the *new regulations or changes to existing regulations*.	Impact will be to participants currently enrolled in the HIPP program who will be canceled. These people will incur 100% of the employee's cost of the group health insurance.
Agency's best estimate of the number of such entities that will be affected. Please include an estimate of the number of small businesses affected. Small business means a business entity, including its affiliates, that (i) is independently owned and operated and (ii) employs fewer than 500 full-time employees or has gross annual sales of less than $6 million.	Estimate that about 300 Medicaid recipients will be impacted by this regulatory change. The regulatory change does not impact small businesses.
All projected costs of the *new regulations or changes to existing regulations* for affected individuals, businesses, or other entities. Please be specific and do include all costs. Be sure to include the projected reporting, recordkeeping, and other administrative costs required for compliance by small businesses. Specify any costs related to the development of real estate for commercial or residential purposes that are a consequence of the proposed regulatory changes or new regulations.	Each HIPP participant canceled from the HIPP Program will become responsible for payment of the employee's share of their employer's group health insurance, which currently is paid in whole or in part by the HIPP Program. The total cost incurred to a person will vary based upon the cost of their insurance versus the amount they had been receiving from the HIPP program. HIPP premium subsidy amounts are based upon the Medicaid aid category for the Medicaid eligible, the age, gender and region of the state where the Medicaid eligible resides. Therefore, the financial impact to the policy holder will vary for each individual case.
Beneficial impact the regulation is designed to produce.	Projected cost savings to the Commonwealth of Virginia for FY 2010 is $600,000 General Fund (GF)

Alternatives

Please describe any viable alternatives to the proposal considered and the rationale used by the agency to select the least burdensome or intrusive alternative that meets the essential purpose of the action. Also, include discussion of less intrusive or less costly alternatives for small businesses, as defined in §2.2-4007.1 of the Code of Virginia, of achieving the purpose of the regulation.

There are no viable alternatives to this proposed regulatory action. Item AAA of the 2009 Appropriations Act directed DMAS to make this change. Absent this action, DMAS will be out of compliance with a General Assembly mandate.

Regulatory flexibility analysis

Please describe the agency's analysis of alternative regulatory methods, consistent with health, safety, environmental, and economic welfare, that will accomplish the objectives of applicable law while minimizing the adverse impact on small business. Alternative regulatory methods include, at a minimum: 1) the establishment of less stringent compliance or reporting requirements; 2) the establishment of less stringent schedules or deadlines for compliance or reporting requirements; 3) the consolidation or simplification of compliance or reporting requirements; 4) the establishment of performance standards for small businesses to replace design or operational standards required in the proposed regulation; and 5) the exemption of small businesses from all or any part of the requirements contained in the proposed regulation.

There is no impact on small businesses.

Public comment

Please summarize all comments received during public comment period following the publication of the NOIRA, and provide the agency response.

DMAS' Notice of Intended Regulatory Action was published in the (10/26/2009) Virginia Register (VR 26:4) for its public comment period from (10/26/2009) to (11/25/2009). The chart below shows the origin of the comments:

Comment Title	Commenter	Date
HIPP	Kelly Brubaker	10/28/09
Hipp eligibility	Malcolm Cash	11/3/09
This revision will hurt families	N. Glassman	11/3/09
Notification of HIPP Eligibility Cancellation	R. Clarke, Parent	11/6/09
No longer eligible?	Valerie Glassman	11/6/09
HIPP Program cancellation	Robbin Clark	11/9/09
Consider the Purpose of 12VAC30-20	John Carvil	11/17/09
Cost Determination	Sue Ellen Carvil	11/17/09
Emergency Regulations Resulting in	Geoffrey Klein	11/25/09

Cancellation from HIPP Program		
HIPP New Emergency Regulation (by email)	Ann Calbi-Alley	10/22/09
HIPP Regs (by email)	Jill A. Hanken	10/26/09

The comments consisted of the following:

Several comments related to how being canceled from the HIPP program would have a financial impact on the family. Also several comments stated that if the Medicaid eligible was dropped from their family health plan there would be no cost savings to the Commonwealth, but instead an increase because Medicaid would become the primary insurance. Several comments related to how the state had not calculated the cost effectiveness of their actual health plan in order to determine program cancellation. Some comments related to a regulatory change that was effective July 23, 2009, changing the HIPP program from a mandatory program to an optional program as well as removing the requirement that the Medicaid eligible must reside in the same household as the policy holder. However, to clarify, the change of the program from mandatory to optional and removing the requirement of living in the same household as the policyholder are not related to the changes presented under the emergency regulation. The emergency regulation was a result of Chapter 781, Item 306 AAA of the 2009 Appropriation Act. Some comments suggested a prorated fee in order to continue to receive HIPP reimbursements, rather than an "all or nothing" approach to HIPP participation. Also, some comments included the past incurred medical costs that were covered under the health insurance plan and how these costs would now become 100% of the state's responsibility should the Medicaid eligible be dropped from the insurance plan. Several people commented that their employer health plan does not offer a variety of health plans, they are offered employee only or family plans, but no other options, and that in order to cover their non-Medicaid children they cover their Medicaid children as well since there is no change in their health insurance premium costs. One comment received regarding changing "may" to "shall" in 30-20-211(c)(5)(f). However, by stating "may" this permits the program to determine if they will pay up to the calculated average monthly cost when the actual cost of the insurance premium is not cost effective because it exceeds the calculated HIPP premium assistance amount. Finally, comments were received about the regulation being an emergency regulation without public input prior to implementation of the emergency regulation; however the nature of emergency regulations is that they are implemented prior to public input.

DMAS Response: DMAS is aware that these changes will have a negative financial impact on some current enrollees in the HIPP program. DMAS is making changes, however, to ensure that the HIPP program becomes overall cost effective for the Commonwealth.

Family impact

Please assess the impact of the proposed regulatory action on the institution of the family and family stability including to what extent the regulatory action will: 1) strengthen or erode the authority and rights of parents in the education, nurturing, and supervision of their children; 2) encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and

one's children and/or elderly parents; 3) strengthen or erode the marital commitment; and 4) increase or decrease disposable family income.

These changes do not strengthen or erode the authority or rights of parents in the education, nurturing, and supervision of their children; or encourage or discourage economic self-sufficiency, self-pride, and the assumption of responsibility for oneself, one's spouse, and one's children and/or elderly parents. It does not strengthen or erode the marital commitment, but may decrease disposable family income for those families who will no longer have DMAS paying for their family health insurance policies.

Detail of changes

Please detail all changes that are being proposed and the consequences of the proposed changes. If the proposed regulation is a new chapter, describe the intent of the language and the expected impact if implemented in each section. Please detail the difference between the requirements of the new provisions and the current practice or if applicable, the requirements of other existing regulations in place.

If the proposed regulation is intended to replace an emergency regulation, please list separately (1) all provisions of the new regulation or changes to existing regulations between the pre-emergency regulation and the proposed regulation, and (2) only changes made since the publication of the emergency regulation.

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12 VAC 30-20-210 A		Definitions	Added definitions and modified existing definitions for Average Monthly Medicaid Cost, Average Monthly wraparound cost, Family member, high deductible health plan, and premium. Deleted definition for premium assistance definition and added definition for premium assistance subsidy.
12VAC 30-20-210 B		Program Purpose	Added clarifying language
12VAC 30-20-210 **D**	12VAC 30-20-210 **C**	Application required	This subsection was moved from sub (D) to sub (C) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210. Added clarifying language that the cost-effectiveness determination occurs only if the HIPP applicant is found otherwise eligible for the program.

12VAC 30-20-210 **C**	12VAC 30-20-210 **D**	Recipient Eligibility	This subsection was moved from sub (C) to sub (D) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210 Deleted extraordinary circumstances clause, modified language for retroactive Medicaid eligibility and clarified Medicare eligibility.
12VAC 30-20-210 **E**.	12VAC30-20-210 **F**	Payments	Added clarifying language. Moved 12VAC30-20-210E.2, Termination date of Premiums to 12VAC-20-210-I.3. Clarified language for Non-Medicaid family members to state no cost sharing will be made by DMAS. Adding language regarding documentation requirements.
12VAC 30-20-210 F and G	12VAC30-20-210E	Guidelines for determining Cost Effectiveness and Determination of Cost Effectiveness.	These two subsections were collapsed into subsection E. DMAS added Cost Effectiveness Evaluation with clarifying language. Renumbered sections, added clarifying language for premium cost effectiveness methodology. Deleted cost effectiveness methodology that has not been utilized since 1999. 12VAC30-20-210G.3 changed to 12VAC30-20-210 H., HIPP Redetermination, clarified this is HIPP redetermination, not Medicaid eligibility redetermination.
12VAC 30-20-210 H		Third party liability	Re-lettered to 210 J.
12VAC30-20-210 I.		Appeal Rights	Re-lettered to 210 K
12VAC30-20-210 J.		Provider Requirements	Re-lettered to 210 L

Changes subsequent to the Emergency Regulation:

Current section number	Proposed new section number, if applicable	Current requirement	Proposed change, rationale, and consequences
12 VAC 30-20-210 A		Definitions	Added definition for Family health plan as a group health plan that covers three or more individuals and family health plans with 3 or more non-Medicaid eligible individuals are not eligible for HIPP participation..
12VAC 30-20-210 **C**	12VAC 30-20-210 **D**	Recipient Eligibility	This subsection was moved from sub (C) to sub (D) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210
12VAC 30-20-210 **D**	12VAC 30-20-210 **C**	Application required	This subsection was moved from sub (D) to sub (C) to more logically reflect the application, eligibility determination, and cost-effectiveness determination process described in 12 VAC 30-20-210.
12VAC 30-20-210 **E**	12VAC 30-20-210 **D**	Cost effectiveness (E) and Recipient eligibility (D)	Moved subsections (E)(1)-(5) (Cost effectiveness evaluation) into subsection (D) (Recipient eligibility), as these components are eligibility factors and not cost-effectiveness factors. Added family healthcare coverage under eligibility exclusions Subsection E (6) is retained in the first paragraph of sub (E).
	12VAC 30-20-210 G		Added consent form requirements
	12VAC 30-20-210 I		Added Program Termination Language non-compliance language and moved Termination of Premiums (E.2) to this section