**Section 120.324 Health Insurance Premium Payment (HIPP) Program**

a) This program provides health insurance coverage for recipients who have health insurance available and have high cost medical expenses. Authorization for the Health Insurance Premium Payment Program (HIPP) was established by section 4402 of OBRA 1990, which added section 1906 to the Social Security Act.

b) Program Provisions

1) The HIPP Program shall provide for the mandatory enrollment of eligible persons in available cost effective group or individual health plans as a condition of medical assistance eligibility. A group health plan is "any plan of, or contributed to by, an employer (including a self insured plan) to provide health care to the employer's employees, former employees, or families of such employees or former employees." An individual health plan is a contract for health insurance coverage between an individual and an insurance company.

2) The Department shall pay health insurance premiums for eligible medical assistance recipients whenever it is likely to be cost effective.

c) Program Standards

1) The HIPP program shall be limited to persons otherwise eligible for medical assistance (excluding spenddown and long term care clients) who have high cost medical conditions such as, but not limited to:

A) Severe arthritis;

B) Cancer;

C) Heart ailment or defect;

D) Liver disease or dysfunction;

E) Kidney disease or dysfunction;

F) Brain disease or disorder;

G) Neurological disease or disorder;

H) Diabetes;

I) Acquired Immune Deficiency Syndrome (AIDS);

J) Organ transplant; and

K) Any other medical condition requiring high cost ongoing medical treatment.

2) To be eligible for medical assistance, a client with a high cost medical condition who can enroll in a group or individual health plan must supply information about the health plan. The client must enroll (or re-enroll) if:

A) the client can enroll on his or her own behalf; and

B) the plan covers the client's high cost medical condition; and

C) the plan is determined by the Department to be cost effective.

3) A client that fails to enroll in a cost effective health plan is ineligible for medical assistance until the next enrollment period and proof of enrollment is provided.

4) Determination of the cost effectiveness shall be made by the Department on a case-by-case basis using prior medical history.

5) Cost effective means the average cost of medical services for the period of time covered by the health insurance premium is at least two and a half times the premium cost for the period.

6) The Department will notify the client that enrollment is necessary because the plan is cost effective. The client will have the right to appeal this determination according to 89 Ill. Adm. Code 102.80.

7) When the policy covers other family members only, the client's share of the premium will be paid by HIPP unless retention of the policy is contingent upon paying premiums for other medical assistance eligible recipients.

8) Payment of premium for a non-eligible family member may be made if necessary to enroll the HIPP participant. A non-eligible family member may reside in another household. Deductibles and co-insurance shall not be paid for the non-eligible family members. Premiums shall not be paid if the non-eligible family member is required to enroll dependents through a divorce order or order for medical support.

9) Health insurance premiums may be paid directly to employers, unions or insurance companies.

10) Clients paying their own premiums shall be reimbursed only if premium payments are made through payroll deduction or the client has already paid the premium. Reimbursement of premium shall only be made after client accumulates a minimum of $50.00 in payments and submits proof of payment.

11) HIPP shall pay deductibles and co-payments based on the Department's medical payment standards.

12) Medical assistance payments shall be made for items and services covered under the Medical Assistance Program that are not covered by the health plan.

13) Premium payments may be made prior to case approval or certification only when it appears likely that the case will be approved or certified and timely payment or enrollment is crucial to the retention of coverage.

14) Assignment of medical support rights provisions shall apply to any health insurance premium for which the Department pays or reimburses the client. If the client receives a return of premium, for any reason, from the insurance carrier, the returned premium must immediately be turned over to the Department or be subject to recovery.

15) Insurance payments for medical services shall be assigned to the medical provider at the time the services are requested. In the event a client receives an insurance payment for medical services that were also paid by the Department, the client must immediately turn the payment over to the Department or be subject to recovery.

(Source: Amended at 38 Ill. Reg. 16214, effective July 17, 2014)