

DMAP Worker Guide VII

Payment of Private Health Insurance Premiums

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A. DMAP Payment of Private Health Insurance Premiums

DMAP pays clients' private health insurance (PHI) premiums when:

- The client is not in an "Excluded Group," and
- The PHI premium is determined cost-effective by DMAP

Use the information in this Worker Guide to determine the clients who should be referred to DMAP for PHI premium payments, and how to make the referral.

1. Excluded Groups

DMAP will not pay PHI premiums for clients who are:

- Non-SSI institutionalized and waived clients whose income deduction (OHI on CMS) is used for payment of health insurance premiums;
- Eligible for reimbursement of cost-effective, employer-sponsored health insurance per OAR 461-135-0990.

2. Referral to DMAP

A case must be screened for PHI premiums, opened (on CMS) as OHP Plus eligible before sending a referral to DMAP.

PHI premium payment referrals must be sent to DMAP on the Premium Referral form (DMAP 3073). In order to comply with HIPAA requirements, PHI referrals must only be sent by shuttle or through the mail. Send completed forms to:

PHI Coordinator – CMU
 DMAP– Operations
 500 Summer St NE E44
 Salem OR 97301-1079

When completing the DMAP 3073, do not leave any area blank, if an area does not apply, write N/A. DMAP will return incomplete referrals to the branch office.

The following information/documentation is needed to complete the DMAP 3073:

- Premium amount
- Type of coverage (major medical, drugs, etc.)
- Name and address of insurance company
- Policy holder's name, group and policy number
- Who the checks are made out to (insurance company, employer, etc.), and the name and address where the checks should be sent
- Client information (name, case number, etc.)
- Medical documentation/information to justify continuing premium payment
 - ◆ A signed and dated original of the Authorization for Use and Disclosure of Health Information (DHS 2099). If employer-sponsored insurance, DMAP needs a completed DHS 2099 for both the employer and the insurer. When completing the DHS 2099, remember: Sections A & B require the **policyholder's** information.

- ◆ Section B—Include either individual or employer-sponsored insurance companies here (including COBRA) and the insurance company's address
- ◆ Section C should always list the DMAP PHI Coordinator's name and address as shown above
- ◆ Section D should be signed by the **policyholder** (or rep); add branch worker's name, agency and location

3. Determining Cost-Effectiveness

DMAP determines PHI premium payment cost-effectiveness by:

- Reviewing the clients past use of medical services under medical programs, third parties, and private insurance.
- Estimating the current and probable future health status of the client based on existing medical conditions or documentation.
- Evaluating the extent/limit of coverage available to the client under any health insurance policy, and the cost of the premium.

4. Hearings

Clients have the right to a hearing to dispute the use of PHI.

All hearings comply with DHS hearings rules and procedures.

Workers schedule pre-hearing conferences for DMAP.

Hearings are held over the phone. Prior to the hearing, DMAP prepares and sends hearing summaries to the parties involved.



PREMIUM REFERRAL FOR PRIVATE HEALTH INSURANCE (PHI)

Today's Date: _____

**Return Referral Via mail or Shuttle
to: PHI Premium Coordinator
OMAP Claims Management, HFO
Human Services Building
500 Summer St NE E44
Salem OR 97301-1079**

Client Information:

Program: _____ Branch: _____ Case Number: _____
 Case Name: _____ Recipient Name: _____
 Worker's Name and Phone Number: _____

Insurance Information:

Policy holder's name: _____ When are premiums due? monthly quarterly
 Policy/Group # _____ Premium Amount \$ _____
 Date next premium due? _____
 Name and address of health insurance company: _____ Name, address, phone number of sponsoring employer:

Medical Condition/Diagnosis (this area must be completed):

Please specify any major medical conditions or other medical information that justifies premium payments.

ATTACH the following:

- A copy of the private health insurance ID card.
- An original signed/dated "Authorization for Use and Disclosure of Health Information" (DHS 2099), allowing DHS to obtain applicant's information from the employer/health insurance carrier.
- A copy of the COBRA approval letter, if premium request is for COBRA coverage.



Print

Clear Form

Authorization for Use & Disclosure of Information

This form is available in alternative formats including Braille, computer disk, and oral presentation.

Section A	Legal Last Name	First	MI	Date of Birth
	Other Names Used By Client/Applicant			Case ID#

By signing this form, I authorize the following record holder (individual, school, employer, agency, or medical or other provider) to disclose the following specific confidential information about me:

Section B	Release From	Specific Information to be Disclosed	Mutual Exchange: Yes / No

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS _____ Mental Health _____ Alcohol/Drug diagnoses, treatment, referral _____ Genetic Testing _____

Section C	Release To (address required if mailed) If releasing to a team, list members	Purpose	Expiration Date or Event*

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

I understand that the information used and disclosed as stated in this authorization may be subject to re-disclosure and no longer protected under federal or state law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, and drug/alcohol diagnosis, treatment, or referral information.

Section D	Full Legal Signature of Individual OR Authorized Personal Representative	Relationship to Client	Date
	Name of Staff Person (print)	Initiating Agency Name/Location	Date

* The authorization is valid for one year from the date of signing unless otherwise specified.

Full Legal Signature of Agency Staff Person Making Copies	This is a true copy of the original Authorization document.
Print Staff Name	

See Important Information on Page 2 of This Form →

Important Information for the Client

To provide or pay for health services: If the Department of Human Services (DHS) is acting as a **provider** of your health care services or paying for those services under the Oregon Health Plan or Medicaid Program, you may choose not to sign this form. That choice **will not** adversely affect your ability to receive health services, *unless* the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. (Examples of this would be assessments, tests or evaluations.) Your choice not to sign **may affect** payment for your services if this authorization is necessary for reimbursement by private insurers or other non-governmental agencies.

This authorization for use and disclosure of information **may also be necessary** under the following situations:

- To determine if you are eligible to enroll in some medical programs that pay for your health care
- To determine if you qualify for another DHS program or service not acting as a health care provider

This is a Voluntary Form. DHS cannot condition the provision of treatment, payment, or enrollment in publicly funded health care programs on signing this authorization, except as described above. However, you should be given accurate information on how refusal to authorize the release of information may adversely affect eligibility determination or coordination of services. If you decide not to sign, you may be referred to a single service that may be able to help you and your family without an exchange of information.

Using This Form

1. **Terms Used: Mutual exchange:** A “yes” allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, a DHS staff person should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative’s authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your DHS staff person. You can remove a team member from the form. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. DHS can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.

Re-disclosure: Federal regulations (42 CFR Part 2) prohibit making any further disclosure of Alcohol and Drug information; state law prohibits further disclosure of HIV/AIDS information (ORS 433.045, OAR 333-12-0270); and state law prohibits further disclosure of mental health, substance abuse treatment, vocational rehabilitation and developmental disability treatment information from publicly funded programs (ORS 179.505, ORS 344.600) without specific written authorization.