



DMAP Worker Guide VII

Health Insurance Premium Payments and Premium Health Insurance programs

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Overview

Oregon Health Plan clients may also have individual (private) or employer-sponsored insurance, also known as Third Party Liability (TPL). Medicaid is the payer of last resort, so the client's TPL normally becomes the primary payer.

The state has two programs that may be able to reimburse OHP clients for the amount they pay for third party insurance. These programs assist the state in providing cost-effective health care.

- HIPP - Health Insurance Premium Payment program – Reimburses eligible policyholder's for the amount they pay for their employer-sponsored health insurance. Payments usually go directly to the policyholder.
- PHI - Private Health Insurance program - Covers insurance premium costs for eligible household members with health care costs estimated (if covered by DMAP) to be higher than the cost of paying the premium. Payments usually go to the insurance carrier instead of the policyholder (although there can be exceptions).

Both HIPP and PHI do **not** pay premiums for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance.
- Vision, dental, long-term care or other stand-alone policies.
- Clients covered by Medicare Part A and/or Part B.

Health Insurance Group

The Health Insurance Group's (HIG) Premium Reimbursement Coordinators, located within the Office of Payment Accuracy and Recovery (OPAR), determine eligibility for both HIPP and PHI. Determining eligibility includes collecting documents from clients, reviewing for cost effectiveness, data entry in MMIS to issue payments and all other administration related to the program. Contact the Coordinators at 503 378-6233 or by e-mail at [HIPP, REIMBURSEMENTS](#) or hipp.reimbursements@state.or.us. Documents can be faxed to 503 378-0358.

Managed care plans

Clients determined eligible for the HIPP or PHI program cannot enroll into a medical managed care plan. Their private or employer sponsored health insurance becomes the primary payer. Any Medicaid services that are not covered by the third party insurance are paid for on a fee-for-service basis.

In the event a client is already enrolled in a managed health care plan at the time third party insurance is reported to HIG, the client will be disenrolled from that plan on the last day of the month it is reported.

HIPP - Health Insurance Premium Payment

Program requirements

The HIPP program provides premium reimbursement for eligible Medicaid clients covered by employer-sponsored group health insurance.

Effective January 1, 2012, the policyholder does **not** have to be in the **same household**. It is possible to reimburse eligible absent parents, grandparents or others who are paying for the health insurance premiums. However, the state does not reimburse for third party insurance premiums if the policyholder has been court ordered to provide it.

As a condition of Medicaid eligibility, employed individuals with CEM, EXT, GAM, MAA, MAF and OHP (except OHP-CHP and OHP-OPU) **must** enroll in their employer-sponsored group health insurance if it is cost effective. Self-employed individuals who opt to purchase group health insurance may also apply for HIPP. *OAR 461-155-0360*

To qualify for HIPP, the employer-sponsored health insurance must be:

1. A comprehensive major medical policy that includes inpatient and outpatient hospital, physician, lab, x-ray and full pharmacy benefits (insurance policies that cover a specific conditions or diseases such as a cancer-only policy or only have a prescription discount card are not eligible); and,
2. Determined cost-effective based on the [Medical Savings Chart \(MSC\)](#); and,
3. Meet HIPP requirements in OAR 410-120-1960.

Note: The state does not reimburse the employer's share of the premium cost.

HIPP eligibility

The HIG coordinator follows these steps when a [MSC415H](#) is received to determine if the employer-sponsored insurance is cost effective:

1. Determine if the Medicaid client has EXT, GAM, MAA, MAF, OSIPM or OHP (excluding OHP-CHP, OHP-OPU and CWM/CWX).
2. Verify the insurance is a major medical policy and record in MMIS.
3. Contact the client for more information if they pay all or part of their premium.
4. Confirm the employee's premium amount and how often it is paid (for example, \$75.00 is taken out of pay every week) with the employer .
5. Compare each eligible client by PERC code to the amount allowed for that PERC code on the [Medical Savings Chart](#). Each person's allowed amount is added to the allowed amount for all other eligibles on the case (in some instances HIG may include people on separate cases). For example, a child may be on their own D4 case but living in the same household with other family members who are on a separate case.

If the premium payment exceeds the combined allowed amount on the MSC, HIG will check to see if anyone in the benefit group qualifies for the PHI program.

6. If *OAR 410-120-1960* and the above requirements are met, HIG authorizes and enters the HIPP reimbursement payment into MMIS.

Reimbursements are paid by check through MMIS. Reimbursements are **no longer** made through the Electronic Benefits Transfer (EBT) process (also known as ReliaCard) nor by workers using the 437 Special Cash Pay process.

7. HIG re-determines eligibility annually or more frequently, if needed

Examples:

- *Mom is employed and her employer provides insurance for Mom, Dad and two children. Only the children are eligible for Medicaid. Dad has \$435.00 deducted from his check each month for his portion of the insurance. The children have PERC codes of H2 and HB. The combined insurance allowance on the [Medical Savings Chart](#) is \$687.00 (\$448.00 for HB and \$239.00 for H2). The cost of their insurance is cost effective because the premium amount is below the allowable amount.*
- *Dad does not live in the household and is not covered by Medicaid, but he provides insurance through his employer for his disabled son who lives in a group home. The son's PERC is D4. The cost of the insurance is \$537.00 per month. The allowance on the [Medical Savings Chart](#) is \$1141.00. The cost of their insurance is cost-effective because the premium amount is below the allowable amount.*
- *Client has a private policy that they purchased. The premium is \$430 per month. The client has cancer. The allowable amount on the [Medical Savings Chart](#) for his XE PERC code is \$249.00. Because the client has an illness that is covered on the [Special Conditions Chart](#), we can add an additional allowance of \$231.00 in our calculation ($\$249.00 + \$231.00 = \$480$). The combined amount is greater than the \$430.00 cost of the premium which makes it cost effective for reimbursement under the PHI program.*

PHI - Private Health Insurance

Program requirements

In special situations, DMAP may pay health insurance (third party) premiums even if the premium is greater than what is allowed on the [Medical Savings Chart](#) (MSC). This may occur when the third-party insurance cost is less than the estimated cost of DMAP paying fee-for-service for their medical care.

Individual **and** employer-sponsored insurance may qualify for the PHI program. Payments for PHI generally go directly to the insurance carrier. However, payments may be paid directly to the policyholder or their representative. PHI **may or may not cover everyone** in the benefit group and the reimbursement may be a pro-rated portion of the premium.

PHI eligibility determination

The HIG coordinator follows these steps to determine if PHI is cost effective:

1. Determine if the Medicaid client has EXT, GAM, MAA, MAF, OSIPM or OHP (excluding OHP-CHP, OHP-OPU and CWM/CWX).
2. Verify the insurance is a major medical policy and record in MMIS.
3. Determine if anyone in the household covered by the third party insurance has a specific medical condition listed on the [Special Conditions Chart](#) (SCC). The listed conditions are associated with higher utilization costs.
4. Confirm the amount and how often insurance premiums are paid with the client or insurance company.
5. If anyone covered by Medicaid and third party insurance has a medical condition covered on the MSC, add the amount for the eligible person(s)' PERC code on the MSC to the amount allowed on the Special Conditions Chart (SCC) and determine if the insurance premium is equal to or less than the combined allowed amounts.
6. If the third party insurance is determined cost-effective and all requirements in OAR-410-120-1960 are met, HIG authorizes and enters the PHI reimbursement payment into MMIS.
7. PHI eligibility is re-determined annually or more frequently, if needed.

How to refer clients for HIPP or PHI

Use the [MSC415H](#) to refer clients for HIPP or PHI eligibility review. E-mail the form to hipp.reimbursements@state.or.us or fax to 503-373-0358. For questions, call a HIG Premium Reimbursement Coordinator at 503-378-6233.

Examples of when to refer a client for the HIPP or PHI program are:

- Client indicates they pay for all or part of a third party insurance on Section 5 of the MSC415H or Extra Form E (part of the 7210 application). Workers may **submit** either the MSC415H **or** Extra Form E.
- Client reports they have COBRA insurance.
- Paycheck stubs show that health insurance is deducted from a paycheck but the client has not submitted a MSC415H. In this case, workers should *pend* for a completed MSC415H and when it is completed, send referral to HIG.
- Client is employed by a company that offers group health insurance, even if the client has opted out. HIG will contact the client or employer to find out if the insurance is cost effective.
- Client is working and indicates they have a private, individual health insurance plan.
Note: Client may purchase health insurance directly from the insurance carrier and it will not show on their paycheck stub.

For instructions on how to complete the [MSC415H](#), go to [OPAR-AR-11-001](#).

Reference

Hearings

Insurance premium reimbursements are not a medical benefit and therefore are not subject to hearings. See OAR 410-120-1960(15).

Questions?

Client or worker questions related to HIPP or PHI should be directed to a Premium Reimbursement Coordinator at 503 378-6233 or e-mail at [HIPP_REIMBURSEMENTS](mailto:HIPP_REIMBURSEMENTS@state.or.us) or hipp.reimbursements@state.or.us. Documents can be faxed to 503 378-0358.

Client questions regarding third party insurance and Medicaid eligibility should be referred to their local DHS branch worker.

Forms

[MSC415H](#)

<https://apps.state.or.us/cf1/DHSforms/Forms/Served/de0415h.pdf>

Other resources

- [Medical Savings Chart](#) (attached)
- [Special Conditions Chart](#) (attached)

Applicable rules

- 410-120-1960
- 410-120-0345
- 410-120-0330
- 410-155-0360
- 461-120-0345
- 461-120-0350
- 461-135-0990
- 461-170-0035
- 461-180-0097
- 461-135-1100

DMAP - Medical Savings Chart (MSC)

The Medical Savings Chart is used to determine eligibility for the Health Insurance Premium Payment (HIPP) and Private Health Insurance (PHI) programs.

Health insurance eligibility group	PERC Code	Cost-effective premium amount (employee cost)
CEM	HD, HE, HF, HG	\$147
OHP-OPC	H1, H2, H3, H4, OHP-OPC	\$239
OHP-OP6	HB, HA	\$448
OHP-OPP	L2, L6, L8, HC	\$705
EXT	XE	\$249
MAA/MAF	2, 82	\$386
SAC	C5	\$1785
OSIP-AB	3, B3	\$495
OSIP-AD	4, D4	\$1141
OSIPM-OAA	1, A1	\$180
Foster Children-SCF	19	\$237
GA	5, GA	\$163

Effective January 1, 2012

Program administered by the Health Insurance Group
Office of Payment Accuracy and Recovery

DMAP - Special Conditions Chart add-on list

The Special Conditions Chart (SCC) is used to determine eligibility for the Health Insurance Premium Payment (HIPP) or Private Health Insurance (PHI) programs when premium amounts exceed the Medical Savings Chart and a recipient has one of the conditions listed below.

CCS2 Code	Description	Average paid per client per month
019	Pancreatic disease – excluding diabetes	\$396
002	Cancer	\$231
009	Blood disorder (sickle cell, hemophilia)	\$213
001	TB, HIV/AIDS, Hepatitis A, B or C	\$173
018	Liver disease	\$157
015	Cardiovascular disorders	\$137
023	Childbirth (if neonatal delivery cost PMPM is \$268)	\$105
012	CNS disorder-Multiple sclerosis, Epilepsy, Cerebral Palsey, Plegia (Quad, Para, Mono), Paralysis, Parkinsons, Huntingtons	\$65
027	Spina bifida	\$65
010	Mental Health disorders (Autism, DD)	\$61
016	Chronic lung disease, COPD	\$55
011	Alcohol & Chemical dependence disorders	\$54
021	Renal disorders (kidney disease)	\$50
005	Diabetes	\$40

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