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DMAP Research, Education and Development Section

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Authorized Signature

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Topic: Medical Benefits

Subject: **Announcement:** Updated DMAP Worker Guide VII - HIPP moved to HIG and other changes

Applies to:

- | | |
|--|---|
| <input type="checkbox"/> All DHS employees | <input type="checkbox"/> County Mental Health Directors |
| <input type="checkbox"/> Area Agencies on Aging | <input type="checkbox"/> Seniors and People with Disabilities |
| <input type="checkbox"/> Children, Adults and Families | <input checked="" type="checkbox"/> Other (please specify): DHS and OHA staff and others identified on the SPD, CAF, AMH and DMAP transmittal lists |
| <input type="checkbox"/> County DD Program Managers | |

Message: DMAP updated and posted Worker Guide VII - Private Health Insurance Premium Payments and Premium Reimbursements to our Web site.

The Health Insurance Premium Payment (HIPP) program moved to the Health Insurance Group (HIG). The original date for the transition was November 1, but end of month processing moved that date forward to October 27, 2011.

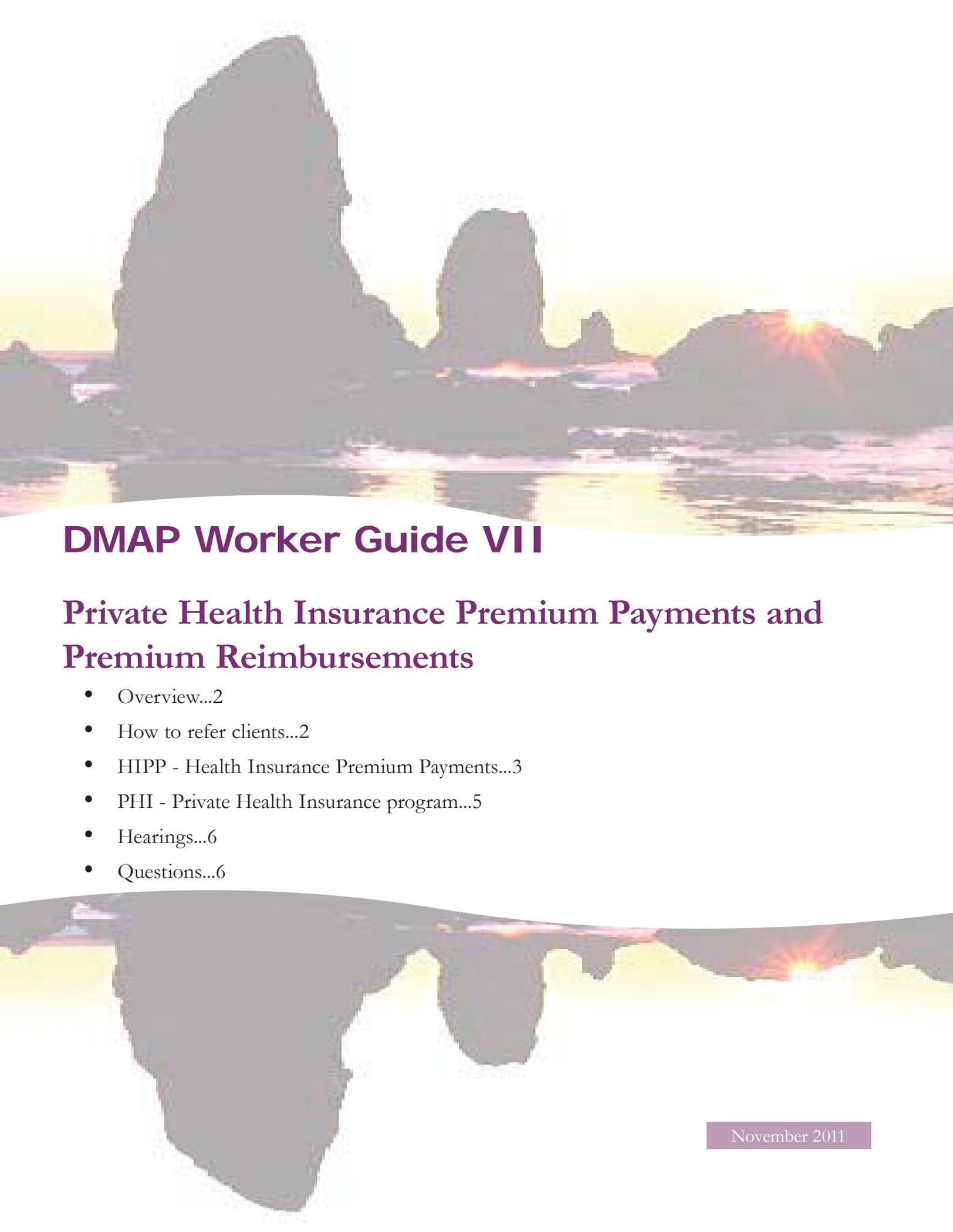
OPAR-AR-11-001 (<http://www.dhs.state.or.us/admin/opar/transmit/ar11001.pdf>) was sent to the field on October 3, 2011. It details the referral process and gives step-by-step directions on how to complete the revised MSC415H.

If you have any questions about this information, contact HIG Premium Reimbursement Coordinators:

Janine Kelty at (503) 378-3324 or Carolyn Thiebes, TPL Analyst, OPAR at 503 378-3507.

If you have any questions about this information, contact:

Contact(s):	Janine Kelty (503) 378-3324 or Janine Kelty (503) 378-3324 or or Carolyn Thiebes, OPAR Analyst, (503) 378-3507		
Phone:		Fax:	
E-mail:	@state.or.us		



DMAP Worker Guide VII

Private Health Insurance Premium Payments and Premium Reimbursements

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Overview

Oregon Medicaid clients may also have private or employer-sponsored medical insurance. When someone is covered by third party insurance it saves the state in capitation payments and fee-for-service (FFS) claims because the third party insurance normally becomes the primary payer. Third party insurance is also known as TPL (third party liability) or TPR (third party resource).

The state has two programs available that may be able to reimburse third party insurance policyholders for the amount that they pay for their third party insurance. The two programs are:

- **HIPP - Health Insurance Premium Payment**
- **PHI - Private Health Insurance**

Both HIPP and PHI programs assist the state in providing more cost-effective health care. However, they are two very *different* programs. HIPP reimburses eligible clients for the amount they pay for their employer-sponsored health insurance. The PHI program pays premiums for insurance policies that are privately purchased and our payments usually go to the insurance carrier instead of the policyholder (although there can be exceptions where the policyholder is paid). The determination process for PHI includes a review of an individual's medical condition(s) and claims payment history and may only cover a select person in the benefit group where HIPP might cover the entire benefit group.

Clients determined eligible for either program cannot enroll into medical managed care plans, and they receive their medical services on a fee-for-service (FFS) basis. Their private or employer-sponsored health insurance becomes their primary payer.

Effective November 1, 2011, eligibility for both programs is determined by the Health Insurance Group (HIG).

How to refer clients for HIPP or PHI

Referrals for the HIPP program are done on the [MSC415H](#). Referrals for the PHI program are done on the [DHS3073](#). They can be e-mailed directly from the forms server or can be faxed to HIG at 503-373-0358.

Examples of when workers should make a HIPP or PHI referral to HIG:

- Client indicates in Section 5 on the MSC415H or Extra Form E that they pay for all or part of their third party insurance.
- Client reports they have COBRA insurance.
- Paycheck stubs show that health insurance is being deducted from a paycheck. In this case, workers should *pend* using the MSC415H and then send the completed form to HIG.

- Client is employed by a company that offers group health insurance even if they aren't already taking the employer-sponsored insurance. HIG will contact the client to find out if the insurance is cost effective.
- Client is working and indicates they have private health insurance even if it is not showing on their paycheck stub.
- Client has a major medical condition and private health insurance where it may be cost effective for the state to pay their premium.

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

HIPP - Health Insurance Premium Payment

HIPP program requirements

The following process is effective **November 1, 2011, to December 31, 2011.**

New eligibility criteria will become effective on January 1, 2012 and we will revise at that time.

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

OAR 461-155-0360 requires that employed individuals in CEM, EXT, GAM, MAA, MAF, and OHP (except OHP-CHP and OHP-OPU) must enroll in their employer-sponsored health insurance, if it is cost effective, as a condition of their Medicaid eligibility. (Note: self-employed individuals who purchase group health insurance may also apply for HIPP).

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

- A comprehensive major medical plan that includes inpatient and outpatient hospital, physician, lab, x-ray and pharmacy benefits. The insurance is not considered major medical if it only covers a specific condition or disease such as a cancer-only policy or if the prescription benefit is a discount card and,
- Determined cost-effective based the HIPP Premium Standard Chart. The state does not reimburse the employer's share of the cost.

HIPP referral process

Effective November 1, 2011, all HIPP determinations are done by a premium reimbursement coordinator at HIG. This includes collecting documentation from clients, reviewing for cost effectiveness, data entry in MMIS to issue payments and all other administration related to the program.

Branch workers are required to make HIPP referrals to HIG on the MSC415H. Examples of when a referral should be made are when:

- A client indicates on the MSC415H that they pay for all or part of their private health insurance.
- A client has COBRA insurance.
- A client does not report TPL, but a worker sees that insurance premiums are being deducted from a paycheck.
- A client indicates that they have private or employer-sponsored insurance.

HIPP eligibility

The following process is effective November 1, 2011, to December 31, 2011.

New eligibility criteria will become effective on January 1, 2012 and we will revise at that time.

HIG uses the following steps to determine if the TPL is cost effective:

- They count the number of people in the benefit group enrolled in EXT, GAM, MAA, MAF, OSIPM and OHP (excluding OHP_CHP and OHP-OPU). HIG counts the people in the benefit group that are covered by both the third party insurance and Medicaid. This may or may not be everyone in the household group.
- They verify the amount of the employee's premium payment with the employer, and how often it is paid (for example, \$75.00 taken out of the employees pay every week).
- They compare the number of eligible people in the benefit group who are also covered by the employer-sponsored health insurance to the amount allowed on the HIPP Premium Standard Chart.
- If the premium is equal to or less than the amount allowed and the insurance is a comprehensive major medical plan, HIG will authorize the HIPP reimbursement in MMIS.

If the client's premium payment exceeds the allowed amount on the chart, HIG will check to see if anyone in the benefit group qualifies for the Private Health Insurance (PHI) program. Please refer to the next section for more information on PHI.

Effective November 1, 2011, all HIPP reimbursements are authorized by HIG and 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.

PHI - Private Health Insurance

PHI program requirements

The following process is effective **November 1, 2011, to December 31, 2011.**

New eligibility criteria will become effective on January 1, 2012 and we will revise at that time.

In special situations, we may pay third party insurance premiums even if the premium is greater than what is allowed on the [HIPP Standard Chart](#). This may occur when the cost for an individual's health insurance is less than the estimated cost of paying for their medical care on a fee-for-service (FFS) basis. HIG may request medical documentation as part of the PHI determination process. In the PHI program, the type of insurance eligible for reimbursement can be a policy that is purchased privately or a policy that is employer-sponsored.

Payments for PHI generally go directly to the insurance carrier; however, in some cases, payments may be paid directly to the policyholder.

DMAP does not pay PHI premium payments for:

- Non-SSI institutionalized and waived clients whose income deduction is used for payment of health insurance premiums.
- Clients eligible for HIPP.

PHI eligibility determination

To determine if a PHI premium payment is cost effective, HIG:

- Reviews client's past claims from state medical programs and/or private insurance.
- Estimates current and probable future health status based on existing medical conditions or documentation.
- Evaluates the extent/limit of coverage under the health insurance policy, and premium cost.

After HIG's review is complete, they notify the client if they are eligible for the program. HIG also notifies the worker. If the request is approved, HIG conducts an eligibility redetermination at least one time per year to ensure the payments are still cost effective. Reviews may be more frequent depending on the client's claims history. In addition, HIG verifies that the insurance is still active each month prior to sending the payments. If it is not active, HIG will notify the client and worker that the premium will no longer be paid.

Hearings

The following process is effective November 1, 2011, to December 31, 2012.

New eligibility criteria will become effective on January 1, 2012. This section will be revised at the end of December 2011 with the new eligibility criteria.

Clients have the right to a hearing to dispute HIPP or PHI determinations. All hearings comply with DHS hearings rules and procedures. Hearings are held over the phone. Prior to the hearing, DMAP prepares and sends hearing summaries to the parties involved.

Questions?

Client or worker questions related to HIPP or PHI should be directed to the Health Insurance Group (HIG) at **503 378-6233**. Client questions regarding third party insurance and Medicaid eligibility should be referred to their local DHS branch worker.

Forms

[MSC415H](#)

[DHS3073](#)

[DHS2099](#)

Other resources

[HIPP Premium Standard Chart](#)

Applicable rules

410-120-1960

410-120-0345

461-120-0330

461-155-0360

461-120-0345

461-120-0350

461-135-0990

461-170-0035

461-180-0097