410-120-1960

Payment of Private Insurance Premiums

(1) Private Insurance Premium (PHI) and Health Insurance Premium Payment (HIPP) are cost saving programs administered by the Authority and the Department for Medicaid enrollees. When a Medicaid client or eligible enrollee is covered by employer sponsored group health insurance or private health insurance, the Authority or Department may choose to reimburse all or a portion of the insurance premium, if it is determined to be cost effective for the Authority or Department.

(2) The Authority or Department may pay health insurance policy premiums or otherwise enter into agreements with other health insurance plans that comply with ORS 414.115 to 414.145 on behalf of eligible individuals when:

(a) The client is enrolled in a full coverage Medicaid program approved by the Authority or Department (excluding CHIP and CAWEM);

(b) The policy is a comprehensive major medical insurance plan (comparable to the Medicaid State Plan coverage) and at a minimum provides the following:

(A) Physician services;

(B) Hospitalization (inpatient and outpatient);

(C) Outpatient lab, x-ray, immunizations; and

(D) Full prescription drug coverage.

(c) The payment of premiums, co-insurance, and deductibles is likely to be cost-effective, as determined under section (5) of this rule;

(d) An eligible applicant may be a non-Medicaid individual living in or outside the household. The Authority or Department may pay the entire premium (excluding the employer's portion) if payment of the premium including the non-Medicaid individual is cost-effective and if it is necessary to include that individual in order to enroll the client in the health plan.

(3) The Authority or Department shall not pay private health insurance premiums for:

(a) Non-SSI institutionalized and waivered clients whose income deduction is used for payment of health insurance premiums;

(b) A policy that has limited benefits where the Authority or Department's annual cost for the premiums exceeds the benefit limits of the policy;

(c) Medicaid eligible clients enrolled in Medicare Part A, Part B, and Part C;

(d) Non-major medical stand-alone policies such as dental, vision, cancer, or accident only;

(e) When the purpose of the policy is providing court ordered health insurance.

(4) The Authority or Department shall assure that all Medicaid covered services continue to be made available to Medicaid-eligible individuals for whom the Authority or Department elects to purchase all or a portion of their private or employer-sponsored health insurance.

(5) Assessment of cost-effectiveness shall include:

(a) The Medical Savings Chart (MSC) is used to obtain the cost effectiveness rate for each Medicaid eligible client;

(b) In cases where there is more than one Medicaid eligible client covered by a single insurance policy, the cost effectiveness rates are combined and compared to the cost of the insurance premium. If the combined cost effectiveness rate total is greater than the cost of the premium, it is approved as cost effective;

(c) If the monthly premium exceeds the allowable amount on the MSC, the Authority or Department may elect to review the current and probable future health status of the Medicaid client based upon their existing medical conditions, previous medical history, age, number of dependents, and other relevant health status indicators. The Authority or Department may apply a special conditions rate in addition to the cost-effectiveness rate on the MSC to determine if their premium is cost effective.

(6) The Authority or Department may purchase documents or records necessary to establish or maintain the client's eligibility for other insurance coverage.

(7) The Authority or Department may not make payments for any benefits covered under the private health insurance plan except as follows:

(a) The Authority or Department shall calculate the allowable payment for a service. The amount paid by the other insurer shall be deducted from the allowable. If the allowable exceeds the third party payment, the Authority or Department shall pay the provider of service the difference;

(b) The payment may not exceed any co-insurance, copayment, or deductible due;

(c) The Authority or Department shall make payment of co-insurance, copayments, or deductibles due only for covered services provided to Medicaid eligible clients.

(8) Any change of insurance coverage shall be reported to the Authority or Department within ten days of the change. If the Authority or Department determines reimbursement of premiums was made on behalf of the client for a policy no longer in effect, the payee shall be liable for repayment to the Authority or Department for the full amount of any overpayment established. To minimize any overpayment made on the client’s behalf, changes that must be reported include but are not limited to:

(a) Private or employer-sponsored insurance no longer active;

(b) Family member added or dropped from health insurance plan;

(c) Change in health insurance plan or health plan coverage;

(d) Change in employer resulting in change in health insurance plan;

(e) Change in health plan premium cost;

(f) Change in employment status (lay off or termination, short-term disability);

(g) Address changes.

(9) As a condition of eligibility, clients must pursue assets (OAR 461-120-0330) and obtain medical coverage (OAR 461-120-0345). Failure to notify the Authority or Department of insurance coverage or changes in coverage and failure to provide periodic required documentation for PHI/HIPP may impact continued eligibility.

(10) If it is determined that reimbursement of premiums is cost-effective, payments shall begin in the next new month following the determination; however, the Authority or Department may approve a retroactive payment when appropriate.

(11) Cancellation of premium payment shall result when:

(a) A client is no longer eligible for a medical program approved by the Authority or Department;

(b) A client is no longer covered by the employer-sponsored or private health insurance plan;

(c) A health insurance premium is no longer cost effective for the Authority or Department;

(d) Failure to submit or complete redetermination forms or provide documentation required by the Authority or Department to complete redetermination;

(e) A client or eligible applicant fails to use the Authority or Department's premium payment reimbursement to pay for their private insurance, if they are required to pay the insurance directly;

(f) The policy-type changes (primary policy changes to a supplemental policy) or the client's eligibility changes to a category that does not meet the requirements in section (2).

(12) The Authority or Department shall determine where approved premium payments shall be sent to: the policy holder (or authorized representative), the employer, insurance carrier, or some other entity.

(13) The client or eligible applicant's receipt of payment under this rule is intended for the express purpose of insurance premium payment or reimbursement of client-paid insurance premium. If insurance is canceled because payment was used for purposes other than premium payment, an overpayment may occur.

(14) Redetermination for HIPP/PHI reimbursement shall occur:

(a) Annually for continued cost effectiveness and may also be reviewed more frequently to ensure insurance is active;

(b) When changes with medical program, insurance eligibility, or employment have been reported or identified;

(c) Other reasons determined by the Authority or Department.

(15) Payment of premiums is a reimbursement and not a medical benefit; therefore, clients do not have hearing rights for a denial of private insurance premium payment. The Authority or Department's decision to place a client in the PHI/HIPP program is a reimbursement and not an eligibility determination nor denial of a medical program benefit.

Stat. Auth.: ORS 413.042
Stats. Implemented: ORS 414.025, 414.065, 414.115, 414.125, 414.135 & 414.145
Hist.: AFS 47-1982, f. 4-30-82 & AFS 52-1982, f. 5-28-82, ef. 5-1-82 for providers located in the geographical areas covered by the branch offices of North Salem, South Salem, Dallas, Woodburn, McMinnville, Lebanon, Albany and Corvallis, ef. 6-30-82 for remaining AFS branch offices; AFS 38-1984, f. 8-30-84, ef. 9-1-84; HR 2-1990, f. 2-12-90, cert. ef. 3-1-90, Renumbered from 461-013-0170; HR 32-1993, f. & cert. ef. 11-1-93, Renumbered from 410-120-0500 & 410-120-0520; OMAP 67-2004, f. 9-14-04, cert. ef. 10-1-04; OMAP 39-2005, f. 9-2-05, cert. ef. 10-1-05; OMAP 15-2006, f. 6-12-06, cert. ef. 7-1-06; OMAP 45-2006, f. 12-15-06, cert. ef. 1-1-07; DMAP 36-2011, f. 12-13-11, cert. ef. 1-1-12; DMAP 40-2015, f. & cert. ef. 7-1-15