



# **DMAP Worker Guide VII**

## **Health Insurance Premium Payments/ Reimbursements**

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## Overview

The state has two programs that are available to assist qualified clients with private or employer sponsored health insurance premium payments. Both programs save the state money when third party insurance carriers become the primary payers. These two programs are:

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

Both the HIPP and PHI programs assist the state in providing more cost-effective health care; however they are two very different programs.

HIPP is a reimbursement program. It includes everyone on the policy who is in the benefit group.

The PHI program pays premiums directly to the insurance carrier (although there can be exceptions where the policyholder is paid). PHI evaluates medical and claims history and may only cover a select person in the benefit group.

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

Effective December 2008, the administration of the PHI program transitioned to HIG (Health Insurance Group), which is part of the Office of Payment Accuracy and Recovery (OPAR). In March of 2009, HIPP will transition to HIG. The new MMIS system requires additional information to process and send payments for both programs.

In order to collect that information, the [DHS3073](#) has been revised. Workers will be required to use the new form in December 2008 for PHI referrals and in March 2009 for HIPP.

## HIPP - Health Insurance Premium Payment

### Program Requirements

Enrollment in employer sponsored health insurance is a condition of eligibility for persons who can enroll themselves or members of the benefit group into their employer sponsored insurance. Self-employed people who have group health insurance may also qualify for HIPP.

To qualify, the employer sponsored health insurance must be:

- A comprehensive plan which includes basic/major medical services. The insurance is not considered comprehensive if it only covers a specific condition or disease such as a cancer-only policy.
- It must be determined cost-effective based on page three of the [HIPP Premium Standard Chart](#). The state does not reimburse the employer's share of the cost.
- Dental insurance may be reimbursed, but only if the combined total of the health and dental

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Payment of Private Health Insurance Premiums

premium is cost effective. If adding dental insurance makes the total premium not cost effective, only the health insurance premium will be reimbursed.

- Starting in March of 2009, HIPP transitions to HIG. Workers will still make eligibility determinations, but HIG will enter the client information into the new MMIS to generate premium payments. When the transition is complete, the [DHS3073](#) will be required for all HIPP payment approvals.

**Eligibility**

To be eligible for HIPP, the amount of the premium paid by the household must be determined cost effective using the following steps:

1. Count the number of people in the benefit group enrolled in any of these programs: EXT, GAM, MAA, MAF, OSIPM and OHP (but not OHP\_CHP and OHP-OPU).
2. Count only the people in the benefit group to be covered by the insurance. This may or may not be everyone in the household group.
3. Identify the amount of the employee’s premium payment and how often it is paid (for example, \$75.00 taken out each bi-weekly check).
4. 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 page three of the [HIPP Premium Standard Chart](#).

If the premium is equal or less than the amount allowed and, the insurance is a comprehensive major medical plan, the worker authorizes reimbursing the client’s premium payments by adding the HIPP coding and amount to the system following current agency guidelines.

When the transition to HIG is complete, this process will change because the new MMIS requires more detailed information. In order to prepare for the transition in March the worker is also asked to do the following:

Complete Sections 1, 2 and 3 of the revised [DHS3073](#). It is available on the DHS forms server and available in both PDF and Word versions. The Word version is interactive and Section 3 assists workers with calculation accuracy.

Once completed fax to HIG at 503 373-0358 the following:

- [DHS3073](#), and
- [DHS0415H](#) or [SPD0415H](#), and
- A copy of the paycheck stub which shows the payment amount.

Once HIG receives all required documents, they update the MMIS system with the necessary information to ensure payment. HIG will verify the client’s case each month to be sure it is still

active. If it is not active, DMAP will no longer pay premiums and HIG will notify both the client and worker.

If the client's premium payment exceeds the allowed amount on the chart, they may still qualify for the Private Health Insurance (PHI) program. Please refer to the next section for more information on PHI.

### Failure to comply with available employer sponsored health insurance

Clients who receive medical assistance (except OHP-CHP and OHP-OPU) must apply for, accept and maintain employer sponsored group health insurance if it is available and cost effective. Clients must report to their workers if insurance becomes available at a later date or, during the employer's annual open enrollment period.

If a person does not cooperate without good cause, they are not eligible for medical assistance, unless they are pregnant. Only the individual who can legally assign rights and obtain the insurance loses medical eligibility for failure to meet this requirement.

## PHI - Private Health Insurance

### Program requirements

In special situations, DMAP may pay for insurance premiums even if the premium is greater than what is allowed on page three of the [HIPP Standard Chart](#). This may occur when the cost for an individual's health services is less than the estimated cost of paying for those services on a fee-for-service (FFS) basis. HIG may request medical documentation before PHI is approved.

Payments for PHI generally go directly to the insurance carrier, however, in some cases, payments may be paid directly to the policyholder. The health plan may be a private individual/family or employer sponsored insurance.

HIG determines if the PHI premium payment is cost effective by:

- Reviewing the client's past claims and payments from state medical programs and/or private insurance carriers.
- 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.

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.

## Referral process

Refer a client for PHI to HIG if:

- The client is ineligible for HIPP because the client's share of the premium exceeds the allowed amount on page three of the [HIPP Standard Chart](#), or
- Their insurance is not an employer sponsored insurance plan, and the client has a medical condition that may make it cost effective for the state to pay the premium.

To make a PHI referral, the worker completes Sections 1 through 4 on the revised [DHS3073](#) and faxes to HIG at 503 373-0358 copies of:

- [DHS3073](#), and
- [DHS0415H](#) or [SDS0415H](#), and
- If available a [DHS2099](#) (Authorization for Use and Disclosure of Information).

Medical records, doctor letters or chart notes, if available, should also be faxed. Workers do not need to request these but if they are available, having them can shorten processing time.

## Determining eligibility

After HIG's review is completed, a letter will be sent to the client and worker. If the request is approved, PHI payments are reviewed each year to ensure the payments are still cost effective. In addition, HIG verifies the insurance monthly prior to sending the payments to be sure the insurance is still active. If it is not active, HIG will notify the client and worker that the premium will no longer be paid.

## Hearings

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?

Call the HIG (Health Insurance Group) at 503 378-6233. This is a DHS staff-only number. Client questions regarding HIPP or PHI payments should be referred to their local DHS branch office or worker.

## Forms

[DHS3073](#)

[DHS0415H](#)

[SDS0415H](#)

[DHS2099](#)

## Other resources

[HIPP Premium Standard Chart](#)

[HIG webpage](#)

## 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