RULES OF

Department of Social Services

Division 70—MO HealthNet Division

Chapter 97—Health Insurance Premium Payment (HIPP) Program

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TITLE 13 — DEPARTMENT OF SOCIAL SERVICES
Division 70 — MO HealthNet Division
Chapter 97 — Health Insurance Premium Payment (HIPP) Program

13 CSR 70-97.010 Health Insurance Premium Payment (HIPP) Program

PURPOSE: This rule establishes that the Department of Social Services, MO HealthNet Division shall pay for the cost of enrolling an eligible MO HealthNet participant in a group or individual health insurance plan when the MO HealthNet Division determines it is cost-effective to do so.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Definitions.

(A) "Group health insurance" shall mean any plan of, or contributed to by, an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees. A group health plan must meet section 5000(b)(1) of the Internal Revenue Code of 1986, as amended, and include continuation coverage pursuant to Title XXII of the Public Health Service Act, section 4980B of the *Internal Revenue Code of 1986*, or Title VI of the Employee Retirement Income Security Act of 1974, as amended. Participation in a health insurance plan that is not group health insurance as defined in this section is not a condition of MO HealthNet eligibility.

(B) "Participant" shall mean MO HealthNet enrollee eligible for comprehensive or full coverage under Medicaid.

(2) Condition of Eligibility. An individual eligible for MO HealthNet, or a person acting on the participant's behalf, shall cooperate in providing information necessary for the MO HealthNet Division to establish availability and cost-effectiveness of group health insurance by completing the Application for Health Insurance Premium Payment (HIPP) Program, Form MO886-3179(2-98). As a condition of MO HealthNet eligibility, persons who are not enrolled in an available group insurance plan which the division has determined is cost-effective, and who are otherwise eligible for MO HealthNet, shall apply for enrollment in the plan.

(A) The Department of Social Services, MO HealthNet Division shall pay all enrollee premiums and deductibles, coinsurance and other cost-sharing obligations for items and services otherwise covered under the MO HealthNet program. Payment of these items is considered as payment for medical assistance; the group health insurance is the primary payer to MO HealthNet. Only coverage of services not provided under the group health plan, but to which the individual is entitled under the MO HealthNet program, shall be provided under MO HealthNet as wrap-around coverage.

(B) When an applicant, participant, parent, guardian, or caretaker fails to provide information necessary to determine availability and cost-effectiveness of group health insurance, MO HealthNet benefits of the applicant, participant, parent, guardian, or caretaker shall be denied unless good cause for failure to cooperate is established. If an applicant, participant, parent, guardian, or caretaker fails to enroll in a group health insurance plan that has been determined cost-effective, or disenrolls from a group health insurance plan the department has determined cost-effective MO HealthNet benefits of the applicant, participant, parent, guardian, or caretaker shall be terminated unless good cause for failure to cooperate is established. Good cause for failure to cooperate shall be established when the applicant, participant, parent, guardian, or caretaker demonstrates one (1) or more of the following conditions exist:

1. There was a serious illness or death of the applicant, participant, parent, guardian, or caretaker or a member of the applicant's, participant's, parent's, guardian's, or caretaker's family.

2. There was a family emergency or household disaster such as a fire, flood, or tornado;

3. The applicant, participant, parent, guardian, or caretaker offers a good cause beyond the applicant's, participant's, parent's, guardian's, or caretaker's control; and

4. There was a failure to receive the department's request for information or notification for a reason not attributable to the applicant, participant, parent, guardian, or caretaker. Lack of a forwarding address is attributable to the applicant, participant, parent, guardian, or caretaker.

(C) MO HealthNet benefits of a child shall not be denied or terminated due to the failure of the parent, guardian, or caretaker to cooperate. Additionally, the MO HealthNet benefits of the spouse of the employed person shall not be denied or terminated due to the employed person's failure to cooperate when the spouse cannot enroll in the plan independently of the employed person.

(3) Cost-effectiveness. Enrollment in a health insurance plan is considered cost-effective when the cost of paying the premiums, coinsurance, deductibles, and other cost-sharing obligations, and additional administrative costs is likely to be less than the amount paid for an equivalent set of MO HealthNet services. When determining the cost-effectiveness of the health insurance plan, the following data shall be considered:

(A) The cost of the insurance premium, coinsurance, and deductible;

(B) The scope of services covered under the insurance plan;

(C) The average anticipated MO HealthNet utilization, by age, sex, geographic location, and coverage group, for persons covered under the insurance plan;

(D) The specific health-related circumstances of the persons covered under the insurance plan; and

(E) Annual administrative expenditures of an amount determined by the MO HealthNet Division per MO HealthNet participant covered under the health insurance policy.

(4) Coverage of Non-MO HealthNet-Eligible Family Members. When it is determined to be cost-effective, the department shall pay for health insurance premiums for non-MO HealthNet-eligible family members if a non-MO HealthNet-eligible family member must be enrolled in the health plan in order to obtain coverage for the MO HealthNet-eligible family members. When the department determines the health insurance plan or policy not to be cost-effective due to the cost of paying for non-MO HealthNet-eligible family members, the department shall consider the cost of the insurance premiums for the policyholder and MO HealthNet-eligible family members only in the determination. This exception shall only apply if the option is available with the health insurance plan. However, the needs of the non-MO HealthNet-eligible family members shall not be taken

into consideration when determining cost-effectiveness, and payments for deductibles, coinsurances, or other cost-sharing obligations shall not be made on behalf of family members who are not MO HealthNet-eligible.

(5) Exceptions to Payment. Premiums shall not be paid for health insurance plans under any of the following circumstances:

(A) The insurance plan is designed to provide coverage only for a temporary period of time (for example, thirty to one hundred eighty (30–180) days);

(B) The insurance plan is a school plan offered on the basis of attendance or enrollment at the school;

(C) The premium is used to meet a spend-down obligation when all persons in the household are eligible or potentially eligible only under the spenddown program. When some of the household members are eligible for full MO HealthNet benefits, the premium shall be paid if it is determined to be cost-effective when considering only the persons receiving full MO HealthNet coverage. In those cases, the premium shall not be allowed as a deduction to meet the spenddown obligation for those persons in the household participating in the spenddown program. As long as the health insurance premium is not used as a deduction to income when determining client participation in the MO HealthNet program, then spenddown coverage shall not exclude a MO HealthNet eligible individual from participating in the HIPP program;

(D) The insurance plan is an indemnity policy which supplements the policyholder's income or pays only a predetermined amount for services covered under the policy (for example, fifty dollars ($50) per day for hospital services instead of eighty percent (80%) of the charge);

(E) CHIP-eligible participants;

(F) Medicare;

(G) Court-ordered health insurance;

(H) The persons covered under the plan are not MO HealthNet-eligible on the date the decision regarding eligibility for the HIPP program is made; or

(I) The participant is enrolled in a MHD managed care plan.

(6) Duplicate Policies. When more than one (1) health insurance plan or policy is available, the Department of Social Services, MO HealthNet Division shall pay only for the most cost-effective plan.

(7) Discontinuance of Premium Payments. When all MO HealthNet-eligible members covered under the health insurance plan lose MO HealthNet eligibility, premium payments shall be discontinued as of the month of MO HealthNet ineligibility. When only some of the MO HealthNet-eligible members covered under the health insurance plan lose MO HealthNet eligibility, a review shall be completed in order to ascertain whether payment of the health insurance premium continues to be cost-effective.

(8) Effective Date of Premium Payment. The effective date of premium payments for cost-effective health insurance plans shall be determined as follows:

(A) Premium payments for cost-effective health insurance plans shall begin with the month the HIPP program application is received by the department, or the effective date of eligibility, whichever is later. If the person is not currently enrolled in the cost-effective health insurance plan, premium payments shall begin in the month in which the first premium payment is due after enrollment occurs; and

(B) In no case shall payments be made for premiums which are used as a deduction to income when determining client participation in the MO HealthNet program.

(9) Method of Premium Payment. Payments of health insurance premiums will be made directly to the insurance carrier except as follows:

(A) The department may arrange for payment to the employer to circumvent a payroll deduction;

(B) When the employer will not agree to accept premium payments from the department in lieu of a payroll deduction to the employee's wages, the department shall prospectively pay the policyholder directly for payroll deductions or for payments made directly to the employer for the payment of health insurance premiums;

(C) When premium payments occur through an automatic withdrawal from a bank account by the insurance carrier, the department may prospectively pay the policyholder for said withdrawals;

(D) When the department is otherwise unable to make direct premium payments because the health insurance is offered through a contract that covers a group of persons identified as individuals by reference to their relationship to the entity, the department shall prospectively pay the policyholder for premium payments made to the entity; and

(E) Participants shall provide documentation to the department of the monthly premium paid by payroll deduction or bank account auto-withdrawal. This documentation must be received by the department on a monthly basis. Failure to provide this documentation on a timely basis may result in non-payment of the HIPP premium by the department or exclusion from the HIPP program.

(10) Reviews of Cost-Effectiveness. Reviews of cost-effectiveness will be completed at least every six (6) months for employer-related group health plans and annually for nonemployer-related group health plans. Additionally, redeterminations shall be completed whenever a predetermined premium rate, deductible, or coinsurance increases, some of the persons covered under the policy lose full MO HealthNet eligibility, there is a change in MO HealthNet eligibility, loss of employment when the insurance is through an employer, or there is a decrease in the services covered under the policy. Participants shall report all changes concerning health insurance coverage to the local Family Support Division's office within ten (10) days of the change.

(11) Notices.

(A) Notice shall be provided to the household under the following circumstances:

1. To inform the household of the initial decision on cost-effectiveness and premium payment (Form MO886-3180(02/05) or Form MO886-3181(02/05));

2. To inform the household that premium payments are being discontinued because MO HealthNet eligibility has been lost by all persons covered under the policy (Form MO886-3182(02/05)); or

3. The policy is no longer available to the family (for example, the employer drops insurance coverage or the policy is terminated by the insurance company, Form MO886-3182(02/05)).

(B) A timely notice shall be provided to the household informing them of a decision to discontinue payment of the health insurance premium because the department has determined the policy is no longer cost-effective (Form MO886-3182(02/05)).

(C) Notice of appeal and hearing rights are as provided for in 208.080, RSMo.

(12) Premium or Rate Refunds. The department shall be entitled

to any premium refund due to overpayment of premium or payment of an inactive policy for any time period for which the department paid the premium. The department shall be entitled to any rate refund made when the health insurance carrier determines a return of premiums to the policyholder is due, because of lower than anticipated claims, for any time period for which the department paid the premium.

(13) Administration. HIPP Program information and forms are currently located and can be accessed on the MO HealthNet Division's website at www.dss.mo.gov/mhd.

(14) Dental and Vision Benefits. Dental and vision insurance policies will not be eligible for premium assistance unless the benefits are part of the medical policy and cannot be separated from the medical policy premium. Dental and vision benefits will be provided to participants through wrap-around coverage.

(15) Cost Sharing. The department must be notified three (3) weeks prior to a Medicaid-covered service to receive prospective payment for any cost sharing obligation. Payment for cost sharing related to services obtained without notice to the department will be reimbursed. Documentation supporting the services occurred, and cost sharing payment was made, must be submitted to the department by the end of the month following the date of service.

AUTHORITY: sections 208.153, 208.201, and 660.017, RSMo 2016. Original rule filed June 30, 1994, effective Jan. 29, 1995. Emergency amendment filed Aug. 19, 2005, effective Sept. 1, 2005, expired Feb. 27, 2006. Amended: Filed June 1, 2005, effective Nov. 30, 2005. Amended: Filed Feb. 1, 2008, effective Aug. 30, 2008. Amended: Filed Dec. 1, 2010, effective June 30, 2011. Amended: Filed Oct. 31, 2022, effective June 30, 2023.*

**Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991, 2007, 2012, 208.201, RSMo 1987, amended 2007, and 660.017, RSMo 1993, amended 1995.*