Oregon Health Authority

Office of Client and Community Services/ Healthy Kids

Information Memorandum Transmittal

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Authorized Signature

Number: SS-IM-12-009
Issue Date: 02/15/2012

Topic: Medical Benefits

Subject: January 1, 2012, Private Major Medical Definition Change Summary and Q&A, and reminder summary of HIPP changes

Applies to (check all that apply):

- ☐ All DHS employees
- ☒ Area Agencies on Aging
- ☐ Children, Adults and Families
- ☐ County DD Program Managers
- ☐ County Mental Health Directors
- ☐ Health Services
- ☒ Seniors and People with Disabilities
- ☒ Other (please specify): SSP transmittal group

Discussion/Interpretation:

Change of *Private Major Medical Health Insurance* Definition

On January 1, 2012, OAR 461-135-1100 was amended to update the definition of *private major medical health insurance*.

- *Private major medical health insurance* is defined as a comprehensive plan which provides the following:
  - Physician services;
  - Hospitalization (inpatient and outpatient);
  - Outpatient lab;
  - X-ray;
  - Immunizations; and

    - Prescription drug coverage.
- If an insurance plan does not provide ***all*** of the services listed above, it is **not** considered *private major medical health insurance*.

OAR 461-135-1100 specifies individuals may not be covered by *private major medical health insurance* and may not have been covered by *private major medical health insurance* for the preceding six months (for OHP-OPU) or two months (for OHP-CHP and Healthy KidsConnect), unless they meet the waiver requirements as defined in the same rule:

- Kaiser Child Health Program and Kaiser Transition Program are **not** considered *private major medical health insurance*; and
- Accessing services through an Indian Health Services (IHS) clinic is **not** considered *private major medical health insurance*.

Q & A – *Private Major Medical Health Insurance*

Question 1: How do I determine if the insurance plan qualifies as private major medical health insurance?

Answer 1: *Contact the insurance company that provides the medical health insurance.*

Question 2: What questions should I ask an insurance company to find out if an insurance plan qualifies as private major medical health insurance?

Answer 2: *Does the insurance policy cover each of the following benefits:*

- *Inpatient and outpatient hospital?*
- *Physician services?*
- *Lab and x-ray?*
- *Any type of prescription benefit?*

You do not need to ask:

- *What the payout amounts are or if there are any limits; or*
- *If the policy is considered a comprehensive or major medical policy.*

Question 3: What if an insurance plan meets all but one of the criteria listed above? For example, the plan provides all of the benefits except for prescription drug coverage.

Answer 3: *If the insurance plan does not meet **all** of the criteria listed above, it does not qualify as private major medical health insurance.*

Question 4: I contacted an insurance company and they said they provide all of the services as listed in OAR 461-135-1100(1). The client told me that for medications, all they get is a prescription discount card. Does that qualify as "prescription drug coverage?"

Answer 4: *Yes. Any prescription drug coverage, including a prescription discount card, meets the requirement "prescription drug coverage" criteria of private major medical health insurance.*

Question 5: Do college student medical plans qualify as private major medical?

Answer 5: *It depends on what benefits their policy contains. It does not matter if the policy is from an employer, a student policy or a policy that is purchased privately. If you have a client with student insurance, follow the same verification process you would for any other insurance policy by contacting the insurance company.*

Question 6: When do I send the MSC 415H to HIG?

Answer 6: *If any of the following occur for someone receiving medical benefits you should send an MSC 415H to HIG:*

- *Client gets new insurance;*
- *Client no longer covered by the third-party insurance;*
- *There are changes to an existing policy;*
- *Someone with third-party insurance is added or removed from the medical case; or*
- *At recertification (this is done because insurance policies change).*

Note: *This applies to all insurance policy types (for example-medical, dental, Medicare supplements) except Medicare and Medicare replacement/ advantage polices. Other than supplements, HIG does not add Medicare related insurance to MMIS.*

All email communications to HIG should be sent to "Referrals TPR" and not to the OPAR-HIG email address.

Question 7: What if my client can get insurance from their employer but they don't have it now? Should I hold up their eligibility and pend them for information about how much the insurance costs and when they could enroll?

Answer 7: *No, you do not need to hold up eligibility. If your client meets all other eligibility criteria, you can open their medical. You will need to send an MSC 415H to HIG and check the "can get insurance from an employer" box that is in Section 2 of the*

form. HIG will contact the client and work with them to see if it is cost-effective to have the client sign up for their employer-sponsored insurance. If the client fails to cooperate in getting the insurance, HIG will contact you.

> ***Note:*** *You do not need to do this step for OPU or CHP clients because pursuit of the insurance would disqualify them from receiving OHP-OPU/OHP-CHP.*

Question 8: Can I refer clients to HIG if they have questions about their insurance?

Answer 8: *Clients should only be referred to HIG if their question is about HIPP/PHI.*

Health Insurance Premium Payment (HIPP) and Private Health Insurance (PHI) program

New rules for the Health Insurance Premium Payment (HIPP) and Private Health Insurance (PHI) program went into effect on January 1, 2012. These changes had an impact on the eligibility process. Now, both programs are administered by HIG. Details of the changes can be found in the following OPAR transmittals: OPAR-AR-11-001, OPAR-IM-11-024 and OPAR-IM-11-025.

Highlights

- Eligibility workers will no longer be able to approve or make HIPP payments. Please do not tell clients they are eligible or send them a notice informing them that they are eligible. Only HIG can determine if someone is eligible for premium reimbursements;
- Clients who are receiving Medicare are no longer eligible for premium reimbursements through the HIPP or PHI program;
- There are no hearings for HIPP/PHI decisions;
- An MSC 415H should be sent to HIG if a client already has employer-sponsored or private health insurance so HIG can determine if they are eligible for HIPP or PHI;
- Employed clients (excluding OPU and CHP) who have not yet signed up for the insurance offered by their employer should be referred to HIG;
- The DHS3073 is obsolete. Please recycle all old copies;
- Once HIG determines an individual is eligible for a HIPP, payments will be sent from MMIS and will be in the form of a check. Payments will no longer be made through EBT or Direct Deposit.

Contact HIG

To make a TPL referral, for questions about how to fill out the MSC 415H or MSC 156, contact HIG in one of the following ways:

Email: Using Outlook, send to Referrals TPR
Outside Outlook, send to TPR.REFERRALS@dhs.state.or.us

Phone: 503 378-6233
Fax: 503 373-0358

For questions about the HIPP or PHI premium reimbursement program, workers or clients can email HIG at:

Using Outlook, send to "Reimbursements HIPP"

Outside Outlook, use reimbursements.hipp@dhs.state.or.us

If you have any questions about this policy, contact:

Contact(s):	Christy Garland	503-947-5519
	Jewel Kallstrom	503-947-2316
	Michelle Mack	503-947-5129
	Carol Berg	503-945-6072
	Joyce Clarkson	503-945-6106
	Vonda Daniels	503-945-6088
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