PROGRAM DESCRIPTION

Department: Social Services **HB Section(s): 11.725**
Program Name: Premium Payments
Program is found in the following core budget(s): Premium Payments

1a. What strategic priority does this program address?

Cost avoidance by paying Medicare and Private Insurance Premiums

1b. What does this program do?

The purpose of the Medicare Savings Program and the Health Insurance Premium Payment (HIPP) Program is to allow states to enroll certain groups of eligible individuals in Medicare or private insurance and pay their monthly premiums to transfer medical costs from the Title XIX Medicaid program to the Medicare program - Title XVIII or other payers. This process allows the state to realize cost savings through substitution of Medicare or other payer liability for the majority of the medical costs before a provider may seek reimbursement for the remaining uncompensated portion of the services.

Medicare Savings Program

Medicare has three sets of basic coverage:

- Part A, which pays for hospitalization costs
- Part B, which pays for physician services, lab and x-ray services, durable medical equipment, and outpatient and other services
- Part D which provides coverage of prescription drug costs (see MORx tab for additional information on Part D)

The Medicare Savings Program assists “dual eligible” individuals, who are entitled to Medicare Part A and/or Part B and are eligible for some form of MO HealthNet benefit, by reducing their out-of-pocket expenses. There are two types of dual eligible—full duals and partial duals. For partial duals, MO HealthNet only funds the Medicare Part A and/or Part B premium. For full duals MO HealthNet funds the Medicare Part A and/or Part B premium and the participant receives MO HealthNet “wrap-around” benefits. Wrap-around benefits include payments for Medicare coinsurance, Medicare deductibles, and any other service not covered by Medicare. *For more information on dual eligibility categories, see Additional Details* .

Health Insurance Premium Payment (HIPP) Program

MO HealthNet purchases group health insurance (such as employer-sponsored insurance) for eligible MO HealthNet participants through the Health Insurance Premium Payment (HIPP) Program. The HIPP program pays for health insurance for MO HealthNet participants when it is determined to be “cost effective.” A plan is considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and administrative costs is likely to be less than the amount paid for an equivalent set of MO HealthNet services. *See additional details for more information on how cost effectiveness is determined.*

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Reimbursement Methodology

Medicare premiums are paid monthly. Payment is made directly to Medicare for the Medicare Savings Program. Any MO HealthNet wrap-around payments (coinsurance, deductibles, or services not covered by Medicare) made on behalf of full dual eligibles is paid out of the applicable fee-for-service lines (Pharmacy, Physicians-Related Services, Hospital, etc.). These wrap-around payments for full dual eligibles are sometimes called "crossover claims." Premiums and cost sharing are paid for the private health insurance through the HIPP Program at the cadence required by the insurance carrier, employer, or participant.

Rate History

Medicare Part A, Part B, and Qualified Individual Premiums (per month)

	Part A	Part B & QI
CY23	$506.00	$164.90
CY22	$499.00	$170.10
CY21	$474.00	$148.50
CY20	$458.00	$135.50

Additional Details

HIPP Cost Effectiveness

Cost effectiveness is determined by comparing the cost of the medical coverage (includes premium payments, coinsurance, and deductibles) with the average cost of each MO HealthNet eligible person in the household. The average cost of each MO HealthNet participant is calculated based on the previous year's MO HealthNet expenditures with like demographic data: age; sex; geographic location; type of assistance (MO HealthNet for Families - MAF, Old Age Assistance - OAA, and disabled); and the types of services covered by the group insurance.

Full Dual Beneficiary Categories

Qualified Medicare Beneficiary (QMB) Plus:

- MO HealthNet pays Part A (if applicable) and Part B premiums
- Individuals below 100% FPL
- Includes MO HealthNet wrap-around benefits

Specified Low-Income Medicare Beneficiary (SLMB) Plus:

- MO HealthNet pays only Part B premiums
- Individuals from 100-120% FPL
- Includes MO HealthNet wrap-around benefits

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Partial Dual Beneficiary Categories

QMB Only:

- MO HealthNet pays both Part A (if applicable) and Part B premiums
- Individuals below 100% FPL
- No MO Health Net wrap-around benefits

SLMB Only:

- MO HealthNet pays only Part B premiums
- Individuals from 100-120% FPL
- No Medicaid wrap-around benefits

Qualified Individuals (QI):

- MO HealthNet pays only Part B premiums
- Individuals from 120-135% FPL
- Federal Funding 100%
- No MO HealthNet wrap-around benefits

Partial “Undesignated”:

- Partial duals with income 135% FPL or greater
- Can include the following individuals:
  - Recipients of supplemental nursing care payments
  - SSI recipients
  - Individuals on spenddown

MO HealthNet pays only Part B premiums.
Individuals receive full MO HealthNet benefits.

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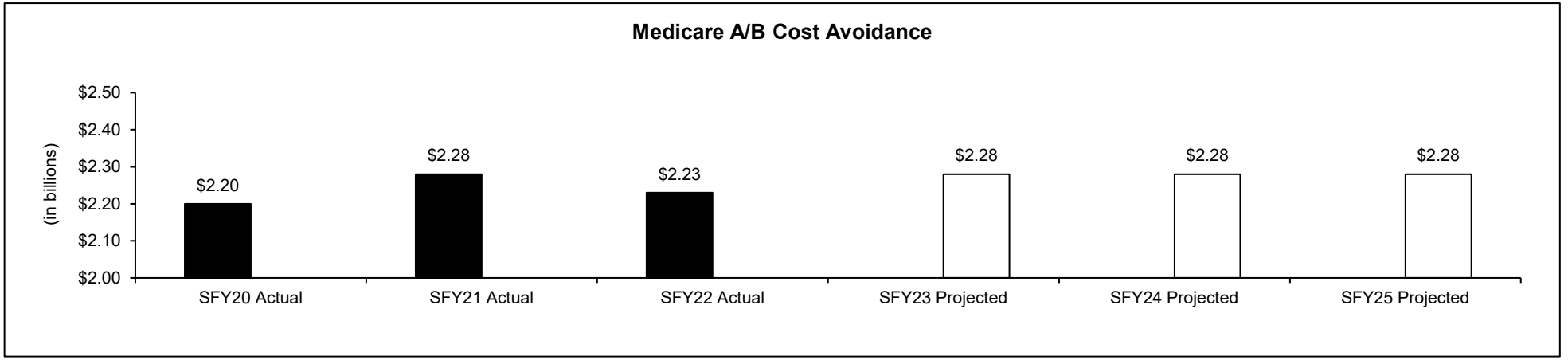
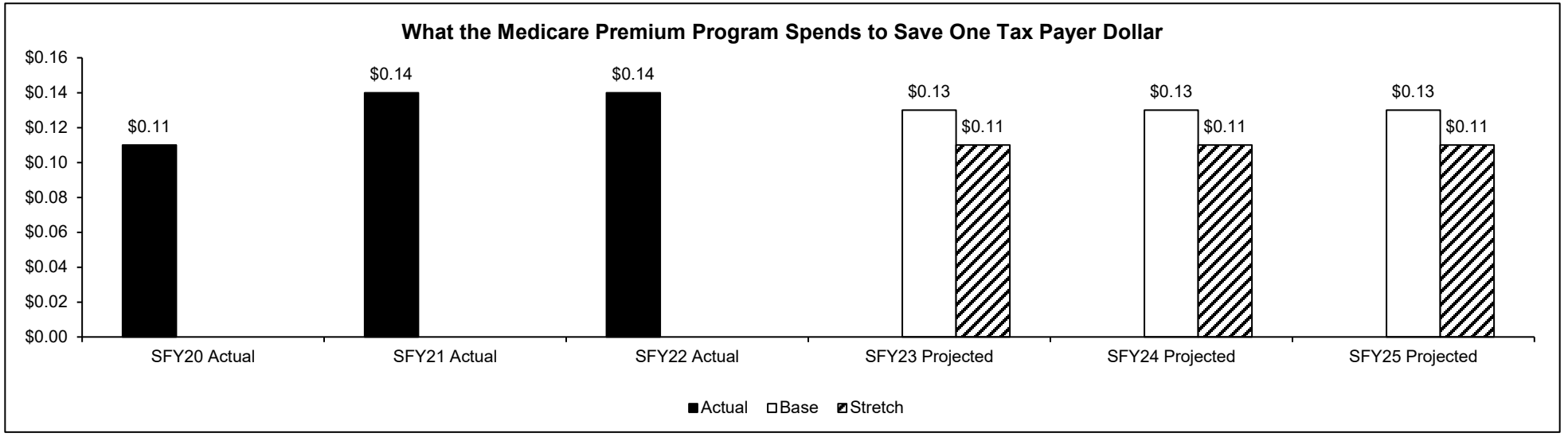
2a. Provide an activity measure(s) for the program.



2b. Provide a measure(s) of the program's quality



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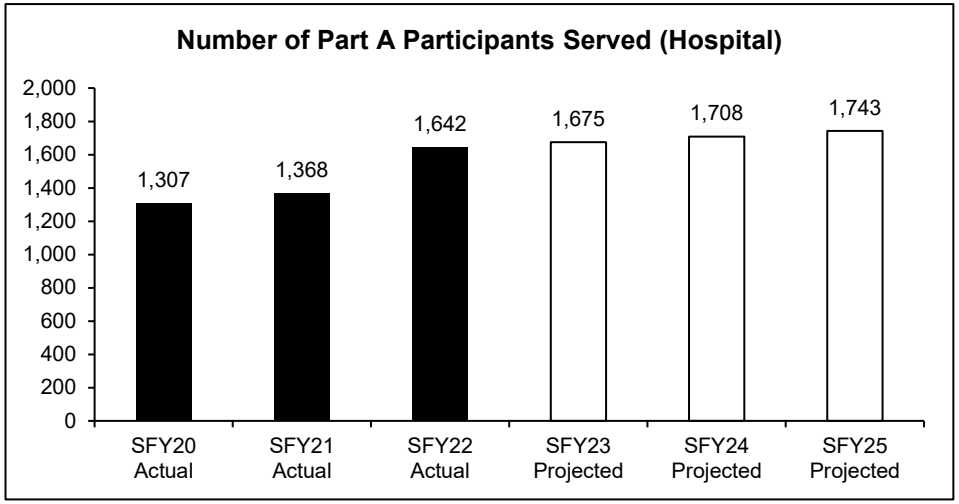
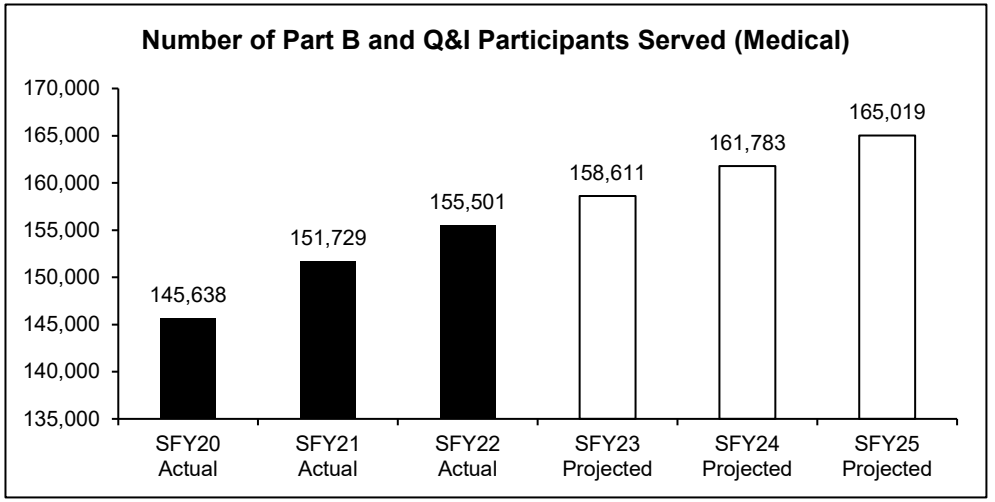
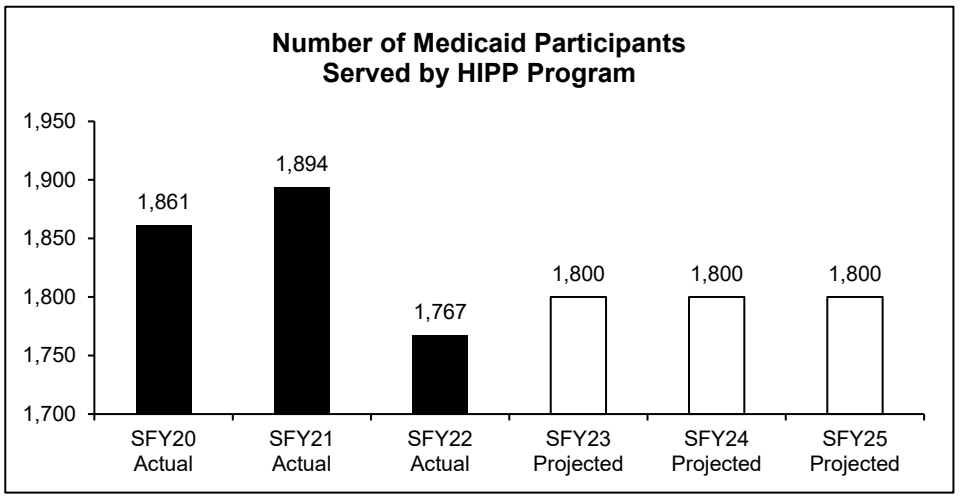
2c. Provide a measure of the program's impact.







Participants:
Part A: (Hospital) premium payments can be made for Qualified Medicare Beneficiaries (QMBs) and Qualified Disabled Working Individuals.
Part B: (Medical) premium payments can be made for Individuals meeting certain income standards, QMBs, and Specified Low-Income Medicare Beneficiaries. The projected increase in the premium participants in FY 24 is due to the increase in participants applying for Medicaid in Missouri.
HIPP: Provisions of OBRA 90 require states to purchase group health insurance for a MO HealthNet participant when it is more cost effective to buy health insurance to cover medical care than to pay for an equivalent set of services with MO HealthNet funds. Enrollment is expected to remain consistent.

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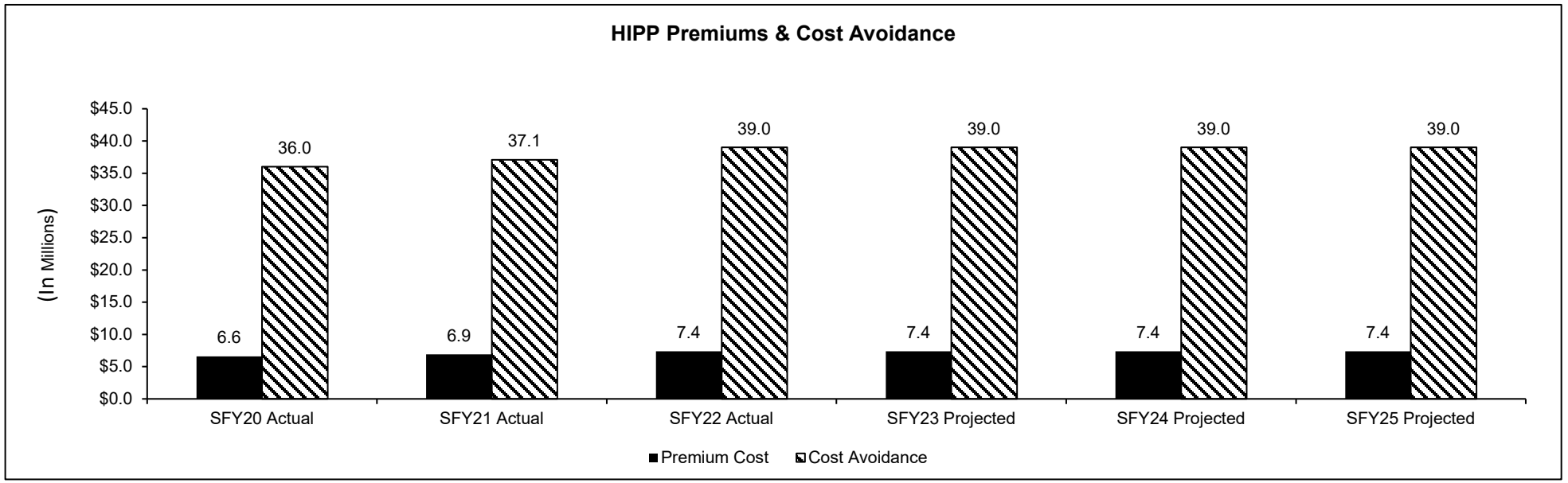
2d. Provide a measure of the program's efficiency.

Paying for health insurance premiums, coinsurance, and deductibles for the MO HealthNet eligible population, when cost effective, increases cost avoidance. In FY23, the MO HealthNet Division paid $7.4 million for health insurance premiums, coinsurance and deductibles and avoided $39 million in costs.



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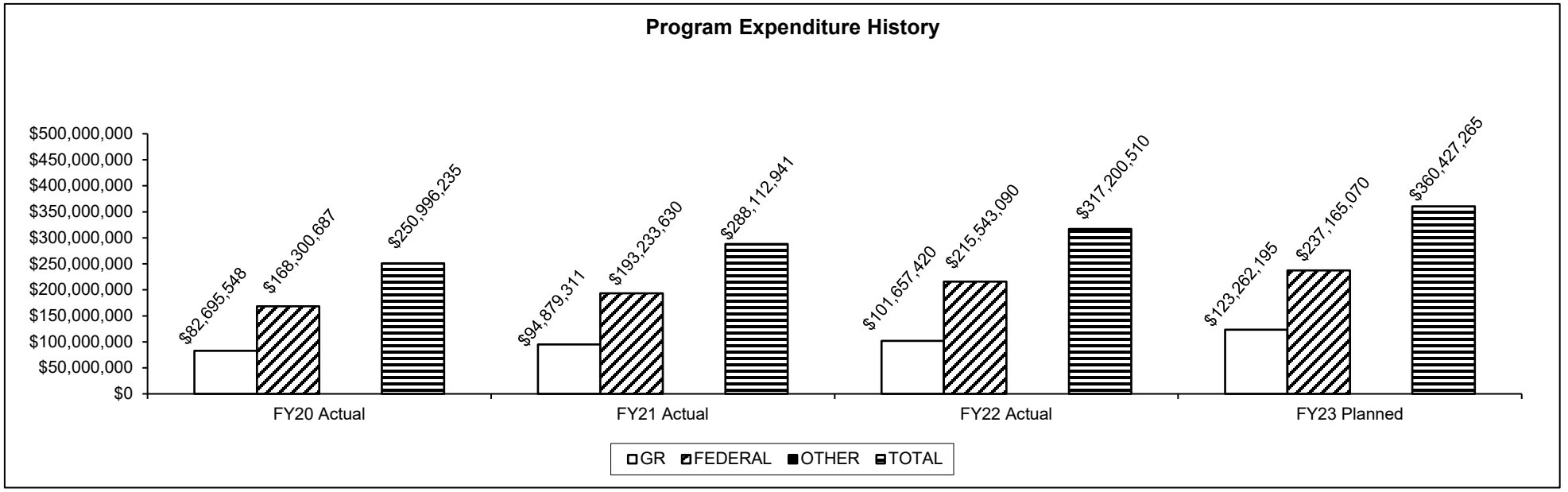
3. Provide actual expenditures for the prior three fiscal years; planned expenditures for the current fiscal year. (*Note: Amounts do not include fringe benefit costs.)*



4. What are the sources of the "Other " funds?

N/A

5. What is the authorization for this program, i.e., federal or state statute, etc.? (Include the federal program number, if applicable.)

State statute: Section 208.153, RSMo.; Federal law: Social Security Act Section 1905(p)(1), 1902(a)(10) and 1906; Federal Regulation: 42 CFR 406.26 and 431.625

6. Are there federal matching requirements? If yes, please explain.

The FMAP (Federal Medical Assistance Percentage) fluctuates annually based on state and national economic and population data, but generally the state matching requirement is around 35% and the federal match is around 65%.

7. Is this a federally mandated program? If yes, please explain.

Yes, if the state elects to have a Medicaid program.