Ohio Administrative Code

Rule 3701-43-20 Providing assistance with health insurance premiums.

Effective: September 1, 2008

(A) As used in this rule:

(1) "Eligible participant" means a recipient who also meets the conditions for eligibility for insurance premium payment assistance set forth in paragraph (B) of this rule.

(2) "Cost-effective" means that the total cost to the program for uncovered services provided to an eligible participant plus the cost for health insurance premiums paid by the program on behalf of the eligible participant plus the associated administrative costs to the program is less than the total anticipated annual costs to the program for authorized services provided to an eligible participant.

(3) "Assistance" means:

(a) The payment of health insurance premiums by the program to a third party or an employer for purposes of providing health insurance coverage for an eligible participant; or

(b) Reimbursement to the eligible participant or the eligible participant's parent, guardian or other legal representative for premiums paid by the eligible participant or the eligible participant's parent, guardian or other legal representative for health insurance coverage for the eligible participant.

Assistance may include payments for premiums for an eligible participant's single coverage under a health insurance plan or payments for premiums for the dependent portion of an insurance plan when the eligible participant is one of a group of dependents who is covered under a health insurance plan.

(4) "Uncovered services" means authorized services provided to an eligible participant that are not covered benefits of the eligible participant's health insurance plan.

(5) "Total anticipated annual costs" means the estimated costs to the department for authorized services if the eligible participant had no health insurance coverage.

(6) "Recipient" has the same meaning as set forth in rule 3701-43-01 of the Administrative Code.

(7) "Family unit" has the same meaning as set forth in rule 3701-43-16 of the Administrative Code.

(B) The director may authorize assistance when a recipient or a recipient's parent, guardian or other legal representative has health insurance coverage for the recipient and both of the following conditions are met:

(1) The health insurance coverage for the recipient is available as a result of a Consolidated Omnibus Budget Reconciliation Act, 26 U.S.C. 4980B (2000), et.seq. ("COBRA") option or the cost of the family's annual health insurance premiums exceed two and one half per cent of the family unit's gross annual earnings; and

(2) The director determines that it is cost-effective; or

(3) The family is unable to access BCMH authorized benefits as a result of primary payor network mandates.

(C) The director shall require that the following written documentation be submitted by the recipient or the recipient's parent, guardian or other legal representative to determine the recipient's eligibility for assistance:

(1) Insurance explanation of benefits (EOBs) or equivalent documentation as determined acceptable by the director for the recipient for the six months preceding the date of the letter that is sent by the department requesting the eligibility documentation;

(2) A notice of premium or equivalent documentation as determined acceptable by the director to document the amount of the monthly insurance premium;

(3) A copy of the COBRA notification and COBRA election forms if a COBRA option is being exercised; and

(4) Any other documentation as required by the director.

(D) The director shall determine the recipient's eligibility for assistance and provide written notification of the determination within thirty days of the receipt of all the required documentation. Assistance with health insurance premium payments will not begin prior to the first day of the month in which all the required documentation is received.

(E) The director shall establish an initial period of eligibility for assistance not to exceed twelve months. The director may establish a continued period of eligibility for assistance for a period not to exceed an additional twelve months based upon a determination of cost-effectiveness to the program.

(F) The recipient or eligible participant or their parent, guardian or other legal representative shall submit, within thirty days of the date of the change, documentation of any changes to income that result in an increase in annual gross earnings, changes to the recipient's or eligible participant's medical condition or treatment thereof, changes to the recipient's or eligible participant's health insurance coverage, or documentation of any other changes that would affect the recipient's or eligible participant's eligibility for assistance.

(G) The director may discontinue assistance or change the terms of assistance if:

(1) The eligible participant or the eligible participant's parent, guardian or other legal representative fails to meet the requirements set forth in paragraphs (B) to (F) of this rule; or

(2) The eligible participant or the eligible participant's parent, guardian or other legal representative fails to pay the health insurance premiums if reimbursement for premiums paid is the method of assistance provided.

(H) The director shall provide the eligible participant or the eligible participant's parent, guardian or other legal representative written notice of the decision to discontinue or change the terms of assistance. Any such discontinuation or change will become effective no sooner than thirty calendar days from the date of the written notice.