PROPOSED AMENDMENT

22 CSR 10-2.020 General Membership Provisions The Missouri Consolidated Health Care Plan is amending sections (3), (5), and (13).

PURPOSE: This amendment revises plan change criteria for Medicare Advantage Plan members, default enrollment procedures, clarifies disabled dependent eligibility, reporting of other health coverage, and renumbers as necessary.

(3) Enrollment Procedures.
(A) Active Employee Coverage.

1. Statewide Employee Benefit Enrollment System (SEBES). A new employee must enroll or waive coverage through SEBES at www.sebes.mo.gov or through another designated enrollment system within thirty-one (31) days of his/her hire date or the date the employer notifies the employee that s/he is an eligible variable-hour employee. If enrolling a spouse or child(ren), proof of eligibility must be submitted as defined in section (5).

2. An active employee may elect, change, or cancel coverage for the next plan year during the annual open enrollment period that runs October 1 through October 31 of each year.

3. An active employee may elect or change coverage for himself/herself and/or for his/her spouse/child(ren) if one (1) of the following occurs:
   A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee’s responsibility to notify MCHCP of the life event.
      (I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or
   B. Employer-sponsored group coverage loss. An employee or his/her spouse/child(ren) may enroll within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances:
      (I) Employer-sponsored medical, dental, or vision plan terminates;
      (II) Eligibility for employer-sponsored coverage ends;
      (III) Employer contributions toward the premiums end; or
      (IV) COBRA coverage ends; or
   C. If an active employee or his/her spouse/child(ren) loses MO HealthNet or Medicaid status, s/he may enroll in an MCHCP plan within sixty (60) days of the date of loss; or
   D. If an active employee or active employee’s spouse receives a court order stating s/he is responsible for covering a child, the active employee may enroll the child in an MCHCP plan within sixty (60) days of the court order.

4. Default enrollment.

[A.] If an active employee is enrolled in the PPO [300 or] 750, PPO [600] 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the same plan enrolled in the prior year at the same level of coverage [in the PPO 1250 Plan provided through the vendor the employee is enrolled in, effective the first day of the next calendar year].

[B. If an active employee is enrolled in the Health Savings Account (HSA) Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the HSA Plan at the same level of coverage.]
[C.] If an active employee is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the employee and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage.

[D.] Married state employees who are both MCHCP members who do not complete enrollment during the open enrollment period, will continue to meet one (1) family deductible and out-of-pocket maximum if they chose to do so during the previous plan year.

[E.] If an active employee is enrolled in dental and/or vision coverage and does not complete open enrollment to cancel coverage or change the current level of coverage during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If an active employee submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the employee of such by mail, phone, or secure message. The employee must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(B) Retiree Coverage.

1. To enroll or continue coverage for him/herself and his/her dependents or spouse/child(ren) at retirement, the employee must submit one (1) of the following:

   A. A completed enrollment form within thirty-one (31) days of retirement date even if the retiree is continuing coverage as a variable-hour employee after retirement. Coverage is effective on retirement date; or

   B. A completed enrollment form thirty-one (31) days before retirement date to have his/her first month’s retirement premium deducted and divided between his/her last two (2) payrolls and the option to pre-pay premiums through the cafeteria plan; or

   C. A completed enrollment form within thirty-one (31) days of retirement date with proof of prior medical, dental, or vision coverage under a group or individual insurance policy for six (6) months immediately prior to his/her retirement if s/he chooses to enroll in an MCHCP plan at retirement and has had insurance coverage for six (6) months immediately prior to his/her retirement.

2. A retiree may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

   A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee’s responsibility to notify MCHCP of the life event.

      (I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

      B. Employer-sponsored group coverage loss. A retiree may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

         (I) Employer-sponsored medical, dental, or vision plan terminates;

         (II) Eligibility for employer-sponsored coverage ends;

         (III) Employer contributions toward the premiums end; or

         (IV) COBRA coverage ends.

3. If coverage was not maintained while on disability, the employee may enroll him/herself and his/her spouse/child(ren) within thirty-one (31) days of the date the employee is eligible for retirement benefits subject to the eligibility provisions herein.

4. A retiree may change from one (1) medical plan to another during open enrollment, but cannot add coverage for a spouse/child(ren). If a retiree is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. **A retiree enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:**

   A. A resident in a long-term nursing facility;
B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”; and
C. Not a Qualified Medicare Beneficiary.

[5./6. Default enrollment.
A. A retiree with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.
   (I) If the retiree or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.
   (II) If the retiree is not able to be enrolled in the Medicare Advantage Plan, [does not have Medicare Part B, and does not complete enrollment during the open enrollment period.] the retiree and his/her dependents without Medicare will be enrolled in the [PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year] same plan enrolled in the prior year at the same level of coverage.
B. If a retiree with Medicare has a non-Medicare dependent [is] enrolled in the PPO [300/750, [or] PPO [600] 1250, or HSA Plan and does not complete enrollment during the open enrollment period, [and has dependents who are not covered by Medicare], his/her dependents without Medicare will be enrolled in [the PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year] the same plan enrolled in the prior year with the same level of coverage.
C. If a retiree without Medicare is enrolled in the PPO [300/750, [or] PPO [600] 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the [PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year] same plan enrolled in the prior year with the same level of coverage.
D. If a retiree without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the retiree is enrolled in at the same level of coverage, effective the first day of the next calendar year.
E./D. If a retiree without Medicare is currently enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled in the TRICARE Supplemental Plan at the same level of coverage, effective the first day of the next calendar year.

[6./7. If a retiree is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the retiree and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

[7./8. If a retiree submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Retiree Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the retiree of such by mail, phone, or secure message. The retiree must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(C) Terminated Vested Coverage.
1. A terminated vested subscriber may later add a spouse/child(ren) to his/her coverage if one (1) of the following occurs:
   A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee’s responsibility to notify MCHCP of the life event.
      (I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or
   B. Employer-sponsored group coverage loss. A terminated vested subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:
(I) Employer-sponsored medical, dental, or vision plan terminates;
(II) Eligibility for employer-sponsored coverage ends;
(III) Employer contributions toward the premiums end; or
(IV) COBRA coverage ends.

2. An enrolled terminated vested subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled terminated vested subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A terminated vested member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:
   A. A resident in a long-term nursing facility;
   B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”; and
   C. Not a Qualified Medicare Beneficiary.

3.A. Default enrollment.

   A. A terminated vested subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.
      (I) If the terminated vested subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.
      (II) If the terminated vested subscriber does not have Medicare Part B, and does not complete enrollment during the open enrollment period, is not able to be enrolled in the Medicare Advantage Plan, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.
       B. If a terminated vested subscriber without Medicare is enrolled in the PPO 750, or HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year with the same level of coverage.
       C. If a terminated vested subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the HSA Plan effective the first day of the next calendar year, at the same level of coverage.
       D. If a terminated vested subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the terminated vested subscriber and his/her dependents will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.
       E. If a terminated vested subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the employee and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

4. If a terminated vested subscriber submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Terminated Vested Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the terminated vested subscriber of such by mail, phone, or secure message. The terminated vested subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

D. Long-Term Disability Coverage.

1. A long-term disability subscriber may add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:
A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee’s responsibility to notify MCHCP of the life event.

(I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or

B. Employer-sponsored group coverage loss. A long-term disability subscriber may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:

(I) Employer-sponsored medical, dental, or vision plan terminates;
(II) Eligibility for employer-sponsored coverage ends;
(III) Employer contributions toward the premiums end; or
(IV) COBRA coverage ends.

2. An enrolled long-term disability subscriber may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If an enrolled long-term disability subscriber is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

3. A long-term disability member enrolled in the Medicare Advantage Plan, may request to change to the PPO 750 Plan if the member is all of the following:

A. A resident in a long-term nursing facility;
B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”; and
C. Not a Qualified Medicare Beneficiary.

3.4. Default enrollment.

A. A long-term disability subscriber with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.

(I) If the long-term disability subscriber or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the long-term disability subscriber [does not have Medicare Part B, and does not complete enrollment during the open enrollment period] is not able to be enrolled in the Medicare Advantage Plan, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the [PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year/same plan enrolled in the prior year with the same level of coverage.

B. If a long-term disability subscriber without Medicare is enrolled in the PPO [300/750, or] PPO [600] 1250, or HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the [PPO 1250 Plan provided through the vendor the long-term disability subscriber is enrolled in, effective the first day of the next calendar year/same plan enrolled in the prior year with the same level of coverage.

C. If a long-term disability subscriber with Medicare [is] has a non-Medicare dependent enrolled in the PPO [300]/750, or] PPO [600]/1250, or HSA Plan and does not complete enrollment during the open enrollment period [and has dependents who are not covered by Medicare], the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the [PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year] same plan enrolled in the prior year with the same level of coverage.

[D. If a long-term disability subscriber without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the long-term disability subscriber is enrolled in at the same level of coverage, effective the first day of the next calendar year.]
If a long-term disability subscriber without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

If a long-term disability subscriber is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the long-term disability subscriber and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

If a long-term disability subscriber submits an Open Enrollment Worksheet or an Enroll/Change/Cancel form that is incomplete or contains obvious errors, MCHCP will notify the long-term disability subscriber of such by mail, phone, or secure message. The long-term disability subscriber must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(E) Survivor Coverage.

1. A survivor without Medicare must submit a survivor enrollment form [and a copy of the death certificate] within thirty-one (31) days of the first day of the month after the death of the employee.
   A. If the survivor does not elect coverage within thirty-one (31) days of the first day of the month after the death of the employee, s/he cannot enroll at a later date.
   B. If the survivor marries, has a child, adopts a child, or a child is placed with the survivor, the spouse/child(ren) must be added within thirty-one (31) days of birth, adoption, placement, or marriage.
   C. If eligible spouse/child(ren) are not enrolled when first eligible, they cannot be enrolled at a later date.

2. A survivor with Medicare will be automatically enrolled as a survivor following the death of the employee.

A survivor may later add a spouse/child(ren) to his/her current coverage if one (1) of the following occurs:

   A. Occurrence of a life event, which includes marriage, birth, adoption, and placement of children. A special enrollment period of thirty-one (31) days shall be available beginning with the date of the life event. It is the employee’s responsibility to notify MCHCP of the life event.
      (I) If paternity is necessary to establish the life event and was not established at birth, the date that paternity is established shall be the date of the life event; or
      B. Employer-sponsored group coverage loss. A survivor may enroll his/her spouse/child(ren) within sixty (60) days due to an involuntary loss of employer-sponsored coverage under one (1) of the following circumstances and the coverage was in place for twelve (12) months immediately prior to the loss:
         (I) Employer-sponsored medical, dental, or vision plan terminates;
         (II) Eligibility for employer-sponsored coverage ends;
         (III) Employer contributions toward the premiums end; or
         (IV) COBRA coverage ends.

A survivor may change from one (1) medical plan to another during open enrollment but cannot add a spouse/child(ren). If a survivor is not already enrolled in medical, dental, and/or vision coverage, s/he cannot enroll in additional coverage during open enrollment.

5. A survivor enrolled in the Medicare Advantage Plan may request to change to the PPO 750 Plan if the member is all of the following:
   A. A resident in a long-term nursing facility;
   B. Eligible for Medicaid nursing home coverage, also known as “vendor coverage”;
   C. Not a Qualified Medicare Beneficiary.

Default enrollment.

A survivor with Medicare and dependents with Medicare will be enrolled in the Medicare Advantage Plan.
(I) If the survivor or a dependent becomes Medicare eligible in January of the next calendar year, they will be enrolled in the Medicare Advantage Plan.

(II) If the survivor [does not have Medicare Part B, and does not complete enrollment during the open enrollment period]is not able to be enrolled in the Medicare Advantage Plan, the survivor and his/her dependents without Medicare will be enrolled in the [PPO 1250 plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]same plan enrolled in the prior year with the same level of coverage.

B. If a survivor without Medicare is enrolled in the PPO [300]750, [or] PPO [600]1250, or HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the [PPO 1250 Plan provided through the vendor the survivor is enrolled in, effective the first day of the next calendar year]same plan enrolled in the prior year with the same level of coverage.

C. If a survivor with Medicare has a non-Medicare dependent [is] enrolled in the PPO [300] 750, [or] PPO [600]1250, or HSA Plan and does not complete enrollment during the open enrollment period [and has dependents who are not covered by Medicare], the survivor and his/her dependents without Medicare will be enrolled in the [PPO 1250 Plan provided through the vendor the retiree is enrolled in, effective the first day of the next calendar year]same plan enrolled in the prior year with the same level of coverage.

D. If a survivor without Medicare is enrolled in the HSA Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the HSA Plan through the vendor the survivor is enrolled in at the same level of coverage, effective the first day of the next calendar year.

E. If a survivor without Medicare is enrolled in the TRICARE Supplemental Plan and does not complete enrollment during the open enrollment period, the survivor and his/her dependents without Medicare will be enrolled in the TRICARE Supplemental Plan effective the first day of the next calendar year, at the same level of coverage.

F. If a survivor is enrolled in dental and/or vision coverage and does not complete open enrollment during the open enrollment period, the survivor and his/her dependents will be enrolled at the same level of coverage in the same plan(s), effective the first day of the next calendar year.

5. If a survivor submits an Open Enrollment Worksheet, an Enroll/Change/Cancel form, or Survivor Enrollment form that is incomplete or contains obvious errors, MCHCP will notify the survivor of such by mail, phone, or secure message. The survivor must submit a corrected form to MCHCP by the date enrollment was originally due to MCHCP or ten (10) business days from the date the notice was mailed or sent by secure message or phone, whichever is later.

(5) Proof of Eligibility. Proof of eligibility documentation is required for all dependents and subscribers, as necessary. Enrollment is not complete until proof of eligibility is received by MCHCP. A subscriber must include his/her MCHCPid or Social Security number on the documentation. If proof of eligibility is not received, MCHCP will send a letter requesting it from the subscriber. Except for open enrollment, documentation must be received within thirty-one (31) days of the date MCHCP processed the enrollment, or coverage will not take effect for those individuals whose proof of eligibility was not received. MCHCP reserves the right to request that such proof of eligibility be provided at any time upon request. If such proof is not received or is unacceptable as determined by MCHCP, coverage will terminate or never take effect. If enrolling during open enrollment, proof of eligibility must be received by November 20, or coverage will not take effect the following January 1 for those individuals whose proof of eligibility was not received. If invalid proof of eligibility is received, the subscriber is allowed an additional ten (10) days from the initial due date to submit valid proof of eligibility.

(G) Disabled Dependent.
1. An [new] employee may enroll his/her permanently disabled child when first eligible or an enrolled permanently disabled dependent turning age twenty-six (26) years and may continue coverage beyond age twenty-six (26) years, provided the following documentation is submitted to the plan prior to the end of the month of the dependent’s twenty-sixth birthday for the enrolled permanently disabled dependent or within thirty-one (31) days of enrollment of [a new employee and his/her] the permanently disabled child:

A. Evidence from the Social Security Administration (SSA) that the permanently disabled dependent or child was entitled to and receiving disability benefits prior to turning age twenty-six (26) years; and

B. A benefit verification letter dated within the last twelve (12) months from the SSA confirming the child is still considered disabled.

2. If a disabled dependent or child over the age of twenty-six (26) years is determined to be no longer disabled by the SSA, coverage will terminate the last day of the month in which the disability ends or will never take effect for new enrollment requests.

3. Once the disabled dependent’s coverage is cancelled or terminated, s/he will not be able to enroll at a later date.

(13) Members are required to disclose to the claims administrator whether or not they have other health coverage and, if so, information about the coverage. [A member may submit this information to the claims administrator by phone, fax, mail, or online. Dependent claims will be denied if the disclosure is not made.] Once the information is received, claims will be reprocessed subject to all applicable rules.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars ($500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars ($500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Consolidated Health Care Plan, Judith Muck, PO Box 104355, Jefferson City, MO 65110. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.