Title 22—MISSOURI CONSOLIDATED HEALTH CARE PLAN
Division 10—Health Care Plan
Chapter 2—State Membership

PROPOSED RULE

22 CSR 10-2.088 Medicare Advantage Plan for Non-Active Medicare Primary Members

PURPOSE: This rule establishes the policy of the board of trustees in regard to the Medicare Advantage Plan for Non-active Medicare-primary members of the Missouri Consolidated Health Care Plan.

(1) The medical benefit for non-Active Medicare primary members is provided through a fully-insured Group Medicare Advantage PPO Plan as regulated by the Centers for Medicare and Medicaid Services (CMS) herein after referred to as the Medicare Advantage Plan. For purposes of this rule non-Active Medicare primary members include: Medicare-eligible members who are eligible retirees, terminated vested subscribers, long-term disability subscribers, and their eligible dependents who have Medicare.

(A) Members must be enrolled in Medicare Parts A and B to be eligible for the Medicare Advantage Plan.

(B) Non-active subscribers that have Medicare and/or their dependents that have Medicare shall receive their medical benefit through the Medicare Advantage Plan.

(C) Subscribers enrolled in the Medicare Advantage Plan will choose another medical plan offered by MCHCP for their non-Medicare dependents.

(D) Beginning the first day of the month in which a non-active Medicare primary member turns sixty-five (65) years old, they shall be transferred to the Medicare Advantage Plan.

(E) A member who opts out of the Medicare Advantage Plan will lose MCHCP eligibility and will not be allowed to enroll in a medical plan at a later date unless otherwise provided for in these rules.

(2) The Medicare Advantage Plan design is defined by the vendor, including deductible, out-of-pocket maximum, and benefits covered. Benefits shall be substantially similar to the benefits offered to non-Medicare members.

(3) The Medicare Advantage Plan eligibility, enrollment, and termination requirements are determined by the plan administrator and are defined in 22 CSR 10-2.020, and in conjunction with the rules set forth by CMS.

(4) Appeals.

(A) Appeals concerning claims and benefits are managed by the vendor in accordance with CMS rules.

(B) Administrative appeals concerning eligibility and termination are managed by MCHCP in accordance with 22 CSR 10-2.075.

AUTHORITY: section 103.059, RSMo 2000. Original rule filed Oct. 30, 2018.

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

PRIVATE COST: This proposed rule 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 rule 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.*