HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1731

PREMIUM ASSISTANCE PROGRAM

§17-1731-1 Purpose. This chapter establishes, subject to the availability of State funds, a premium assistance program for a low-income individual who purchases a silver level qualified health plan through the Hawaii health insurance exchange and receives advanced premium tax credit (APTC) and maximum cost-sharing reduction (CSR). The department shall pay the eligible individual's share of the premium to the qualified health plan in which the eligible individual is enrolled. [Eff 02/27/15] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1731-2 Definitions. The following definitions shall apply to this subchapter:

"Exchange" means the Hawaii health insurance exchange established under the Affordable Care Act.

"Qualified health plan" means a qualified health plan or a qualified health plan issuer, as those terms are defined in 45 C.F.R. §155.20, and as the context may dictate. [Eff 02/27/15] (Auth: HRS §346.14) (Imp: HRS §346.14)

§17-1731-3 Eligibility requirements. To be eligible for the premium assistance described in this chapter, an individual shall:

(1) Have selected or be enrolled in a 94% actuarial value silver level qualified health plan through the Exchange;

(2) Be determined eligible for advanced premium tax credit (APTC), apply the maximum APTC amount available towards their premium and the maximum cost-sharing reduction (CSR) by the Exchange;

(3) Have household income of less than one hundred percent of the federal poverty level for the applicable household size as determined by the Exchange and communicated by the Exchange to the qualified health plan selected by the individual.

[Eff 02/27/15] (Auth: HRS §346.14) (Imp: HRS §346.14)

§17-1731-4 Benefits. (a) The department shall, upon presentation of an invoice by a qualified health plan to the department, pay the share of premium that the eligible individual is required to pay to the qualified health plan to receive coverage.

(b) Benefit limitations:

(1) The department shall pay an eligible individual's share of premium to the qualified health plan only upon receipt of an invoice submitted by the qualified health plan to the department;
(2) The department shall not make any payments directly to eligible individuals; and
(3) The department shall not pay and the eligible individual shall be responsible for, any cost-sharing including, but not limited to, deductibles, co-payments or co-insurance.

(c) The department is not responsible for ensuring that the qualified health plan timely submits an invoice for an eligible individual's share of premium to the department. [Eff 02/27/15] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1731-5 Termination of premium assistance. Premium assistance payable under this chapter on behalf of an eligible individual shall be terminated at any time for any of the following reasons:
(1) The individual fails to meet the eligibility requirements set forth in section 17-1731-3;
(2) The individual voluntarily terminates participation in the premium assistance program;
(3) The individual no longer resides in the State;
(4) Death of the individual;
(5) The individual's whereabouts are unknown;
(6) Insufficient State funds; or
(7) The premium assistance program is terminated. [Eff 02/27/15] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1731-6 Administration of the premium assistance program. (a) The department may contract with a third party or parties to administer any

component of this program, including, but not limited to, payment, auditing, and recovery.

(b) The department's provision of premium assistance under this chapter shall be administered at no cost to the eligible individual.

[Eff 02/27/15] (Auth: HRS §346-14) (Imp: HRS §346-14)

17-1731-7 Appeal process. (a) An eligible individual may appeal the department's failure to pay the benefit described in section 17-1731-4 only as provided in this section.

(b) Issues relating to the determination of an individual's household income by the Exchange under section 17-1731-3(3) must be directed to the Exchange.

(c) Issues relating to a qualified health plan requiring premium payment from an eligible individual must be directed to the qualified health plan before requesting informal review or an administrative hearing under this section.

(d) Requests for an informal review or administrative hearing under this chapter may be submitted by an eligible individual or the individual's authorized representative only when:

(1) The qualified health plan is requiring premium payment from the eligible individual; and

(2) The qualified health plan states in writing that the reason for requiring premium payment is because the department did not timely pay an invoice that was submitted by the individual's health plan to the department.

(e) An eligible individual or the individual's authorized representative may request an informal review.

(1) A request for an informal review must:

(A) Be submitted in writing and received by the department within thirty (30) calendar days after the date of the bill sent by the qualified health plan to the individual.

(B) Include both a copy of the bill sent by the qualified health plan to the individual and a copy of the notice from the qualified health plan stating that the individual was sent a bill because the department did not timely pay the health plan's invoice.

(2) The eligible individual is not required to seek an informal review prior to filing a request for an administrative hearing.

(3) The department shall respond in writing to the request for an informal review and provide notice to the eligible individual of the right to request an administrative hearing under subsection (f). An individual shall have fifteen (15) calendar days from the date of the informal review decision to file a request for an administrative hearing.

(f) An eligible individual or the individual's authorized representative may file a request for an administrative hearing.

(1) A request for an administrative hearing must:

(A) Be submitted in writing and received by the department within thirty (30) calendar days after the date of the bill sent by the qualified health plan to the individual, or within fifteen (15) calendar days from the date of the decision notice for an informal review.

(B) Include both a copy of the bill sent by the qualified health plan to the individual and a copy of the notice from the health plan stating that the individual was sent a bill because the

department did not timely pay the health plan's invoice.

(2) The provisions of chapter 17-1703.1 shall not apply to appeals under this chapter, except for section 17-1703.1-6.

[Eff 02/27/15] (Auth: HRS §346-14) (Imp: HRS §346-12)

§§17-1731-8 to 17-1731-10 (Reserved)