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# EMERGENCY RULE

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## TITLE 22 – MISSOURI CONSOLIDATED HEALTH CARE PLAN Division 10 – Health Care Plan Chapter 2 – State Membership

### EMERGENCY AMENDMENT

**22 CSR 10-2.020 General Membership Provisions** The Missouri Consolidated Health Care Plan is amending section (3).

*PURPOSE: This emergency amendment clarifies enrollment procedures when an eligible dependent loses MO HealthNet or Medicaid status and when a member becomes Medicare eligible.*

*EMERGENCY STATEMENT: This emergency amendment must be in place by January 1, 2025, in accordance with the new plan year. Therefore, this emergency amendment is necessary to serve a compelling governmental interest of protecting members (employees, retirees, officers, and their families) enrolled in the Missouri Consolidated Health Care Plan (MCHCP) from the unintended consequences of confusion regarding eligibility or availability of benefits and will allow members to take advantage of opportunities for reduced premiums for more affordable options without which they may forego coverage. Further, it clarifies member eligibility and responsibility for various types of eligible charges, beginning with the first day of coverage for the new plan year. It may also help ensure that inappropriate claims are not made against the state and help protect the MCHCP and its members from being subjected to unexpected and significant financial liability and/or litigation. It is imperative that this amendment be filed as an emergency amendment to maintain the integrity of the current health care plan. This emergency amendment fulfills the compelling governmental interest of offering access to more convenient and affordable medical services to members as one (1) method of protecting the MCHCP trust fund from more costly expenses. This emergency amendment reflects changes made to the plan by the Missouri Consolidated Health Care Plan Board of Trustees. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment complies with the protections extended by the **Missouri and United States Constitutions** and limits its scope to the circumstances creating the emergency. The MCHCP follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances. This emergency amendment was filed October 25, 2024, becomes effective January 1, 2025, and expires June 29, 2025.*

#### (3) Enrollment Procedures.

##### (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.

**C. If a retiree subscriber's eligible dependent loses MO HealthNet or Medicaid status, the retiree may enroll the eligible dependent within sixty (60) days of the date of loss.**

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.

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, the retiree and his/her dependents without Medicare will be enrolled in the same plan enrolled in the prior year at the same level of coverage.

B. If a retiree with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 1250, or HSA Plan and does not complete enrollment during the open enrollment period, 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 retiree without Medicare is enrolled in the PPO 750, PPO 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 same plan enrolled in the prior year with the same level of coverage.

D. If a retiree without Medicare is currently enrolled

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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.

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.

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.

**C. If a terminated vested subscriber's eligible dependent loses MO HealthNet or Medicaid status, the terminated vested subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.**

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.

4. 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 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, PPO 1250, 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 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.

D. 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.

5. 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.

**C. If a long-term disability subscriber's eligible dependent loses MO HealthNet or Medicaid status, the long-term disability subscriber may enroll the eligible dependent within sixty (60) days of the date of loss.**

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

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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.
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 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 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 750, PPO 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 same plan enrolled in the prior year with the same level of coverage.

C. If a long-term disability subscriber with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 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 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 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.

E. 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.

5. 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 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.

3. 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.

**C. If a survivor's eligible dependent loses MO HealthNet or Medicaid status, the survivor may enroll the eligible dependent within sixty (60) days of the date of loss.**

4. 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”; and

C. Not a Qualified Medicare Beneficiary.

6. Default enrollment.

A. 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 is not able to be enrolled in the Medicare Advantage Plan, the survivor 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 survivor without Medicare is enrolled in the PPO 750, PPO 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 same plan enrolled in the prior year with the same level of coverage.

C. If a survivor with Medicare has a non-Medicare dependent enrolled in the PPO 750, PPO 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 same plan enrolled in the prior year with the same level of coverage.

D. 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.

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E. 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.

7. 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.

**(F) Medicare.**

**1. When a member becomes eligible for Medicare, the member must notify MCHCP pursuant to 22 CSR 10-2.020.**

**2. Non-active employee subscribers will be charged the Medicare Advantage Plan premium the first month after the member's Medicare Beneficiary Identifier (MBI) number is received by MCHCP.**

**3. If a member does not enroll in Medicare Part A when eligible, the member shall continue to be charged the premium for the plan in which they are enrolled and will not receive the Medicare premium until proof of enrollment in the form of the MBI number is received by MCHCP. If a member enrolls in Part A, but does not enroll in part B, the member will be charged the Medicare premium, but will be responsible for the charges Medicare Part B would have paid on a claim. This amount will not be added to the annual deductible or out of pocket accumulations.**

**4. Once MCHCP receives the MBI number, and the member is not an active employee, they will be transferred to the Medicare Advantage Plan defined in 22 CSR 10-2.088.**

*AUTHORITY: section 103.059, RSMo 2016. Emergency rule filed Dec. 16, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency rule filed April 4, 1994, effective April 14, 1994, expired Aug. 11, 1994. Original rule filed Dec. 16, 1993, effective July 10, 1994. For intervening history, see the **Code of State Regulations**. Emergency amendment filed Oct. 25, 2024, effective Jan. 1, 2025, expires June 29, 2025. An emergency amendment and proposed amendment covering this same material will be published in the Dec. 2, 2024, issue of the **Missouri Register**.*

*PUBLIC COST: This emergency amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the time the emergency is effective.*

*PRIVATE COST: This emergency amendment will not cost private entities more than five hundred dollars (\$500) in the time the emergency is effective.*