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NATIONAL ALLIANCE OF STATE & TERRITORIAL AIDS DIRECTORS

Issue Brief: Insurance Purchasing and Continuation

Part B of the Ryan White HIV/AIDS Treatment Modernization Act (Ryan White Program) established federally funded, state-administered AIDS Drug Assistance Programs (ADAPs) to provide access to HIV medications for low-income, uninsured, and underinsured people living with HIV/AIDS (PLWHA) in the United States. Among the many services funded by the Ryan White Program is insurance assistance, which includes financing the purchase of new health insurance policies for clients (insurance purchasing) or paying for premiums, co-payments, and deductibles to allow the continuation of existing health insurance coverage for clients (insurance continuation). Ryan White Program funds may provide insurance assistance to ADAP-eligible PLWHA through: maintenance of COBRA insurance continuation; State High Risk Health Insurance Pools; state-funded health programs; Pre-existing Condition Insurance Plans (PCIPs); the purchase of individual or group health insurance policies; or through Medicare Part D and Medicaid. ADAPs may provide insurance assistance through payments of premiums, deductibles, co-pays, co-insurance, or True out of Pocket (TrOOP) expenditures for Medicare Part D eligible PLWHA. Ryan White Program funds can be used by state Part B/ADAP programs for this purpose. Subsequent policy guidance issued by the Department of Health and Human Services has clarified and expanded state authority in this area and extended it to apply to the use of Part A funds. In addition, several states have used state general revenue funds for insurance assistance programs.

The majority of states have implemented some form of insurance assistance program to enable clients to access comprehensive health care (beyond access to medications alone) for eligible PLWHA, including primary and specialty medical care, prescribed medications, and preventive health education.

The Affordable Care Act (ACA) will expand access to Medicaid and Marketplace Qualified Health Plans (QHPs) for tens of thousands of people living with HIV. ADAP client data from NASTAD's *National ADAP Monitoring Project* indicate that 54% of ADAP clients have income between 100% and 400% of the federal poverty level (FPL), and many of these clients will be eligible for federal subsidies to purchase QHPs in the Marketplaces. For states that do not expand Medicaid, there may also be an opportunity to purchase (unsubsidized) QHPs through the Marketplaces for those with income under 100% FPL who are unable to qualify for Medicaid coverage under current Medicaid eligibility criteria and will also be ineligible for the federal Marketplace subsidies.

2014 ACA Coverage Option	**Income Eligibility Threshold**
Medicaid Expansion	Income up to 138% FPL
Advance Premium Tax Credit for purchase of private insurance through marketplaces	Income between 100 and 400% FPL (ineligible for Medicaid or affordable employer-based coverage)
Cost-sharing subsidies to offset out-of-pocket costs of private insurance through marketplaces	Income between 100 and 250% FPL (ineligible for Medicaid or affordable employer-based coverage)
Unsubsidized private insurance coverage through marketplaces	Income below 100% FPL (ineligible for Medicaid)

To prepare for ADAP-eligible PLWHAs enrollment in QHPs offered through the Marketplace and/or State Medicaid Expansion, many Part B programs and their ADAPs are implementing or ramping up insurance assistance programs to ensure that clients will be able to meet premium and cost-sharing obligations as

they enter into new coverage. This issue brief will discuss the basics of insurance purchasing and continuation programs as well as highlight state activities to prepare ADAPs for health reform. For questions, contact Britten Pund or Amy Killelea.

Insurance Purchasing and Continuation Programs: The Basics

The extent to which state Part B/ADAPs use Ryan White Program funds to purchase or continue insurance coverage for eligible PLWHA depends on several factors. These factors include state and federal insurance law and reform; state ADAPs' capacity to develop and manage such programs; and the availability of resources for this purpose. Insurance purchasing and continuation programs can diversify ADAP services and maximize available funding resources, but require clear policy guidelines for eligible PLWHA, medical providers, case managers, and the medication distribution system.

ADAPs provide insurance coverage to clients in several ways:

- For insurance continuation: Consolidated Omnibus Budget Resolution Act (COBRA) of 1986 health resolution benefits can be continued for up to 18 months (plus a 20-month extension for individuals leaving employment due to disability) after separation from the institution with whom the policy was started. When COBRA benefits end, Ryan White Part B funding can be used to convert the policy to an individual policy, with an increase in the premium. A decision to convert this policy should directly reflect the monthly premium rate and the cost-effectiveness of that rate.

- For insurance purchasing: State ADAPs can purchase insurance (including payment of client premiums, deductibles, and co-payments) through the following:

    - *Private insurance market*
      Many ADAPs assist clients in meeting premium and cost-sharing obligations for individual or employer-based private insurance coverage. The ACA will expand the private insurance coverage options for people living with HIV by eliminating many discriminatory insurance practices (e.g., pre-existing condition exclusions) and by putting in place Marketplaces where people can compare and purchase private insurance plans. Federal premium tax credits and cost-sharing subsidies will also be available to help people afford private insurance coverage. QHPs sold through Marketplaces will have to meet certain benefits, provider network, and non-discrimination requirements, but there may still be plan-by-plan variation in terms of scope of coverage and care and treatment limitations.

    - *State high-risk health insurance pools/state-funded health programs*
      State high-risk health insurance pools are special programs created by state legislatures to provide a safety net for people who have been denied health insurance coverage because of a pre-existing health condition, or who can only access private coverage that is restricted or has extremely high rates. Generally, the programs operate as a state-created nonprofit association overseen by a board of directors made up of industry, consumer, and state insurance department representatives. The board contracts with an established insurance company to collect premiums, pay claims and administer the program. Insurance benefits vary, but risk pools typically offer benefits that are comparable to basic private market plans. As states transition to ACA implementation, many state high risk pools will be closing and clients will transition to new coverage through either the ACA's Medicaid expansion or through QHP coverage available through Marketplaces.

- *Pre-existing Condition Insurance Plans (PCIPs)*
  To provide a bridge to 2014 when many of public and private insurance coverage expansions go into effect, starting in 2010 the ACA requires every state to have a PCIP to provide insurance coverage to people with pre-existing conditions who are not eligible for public insurance and cannot access insurance in the private market. A person must be a U.S. citizen, be uninsured for six months, and provide a letter from an insurance company denying coverage. States had the option of running their own PCIPs or allowing the federal government to run the PCIP. Many states have allowed ADAP to pay for clients' premiums and co-payments for PCIP coverage, and as of December 2012 nearly 5,000 ADAP clients nationwide were enrolled in PCIPs. People currently enrolled in PCIPs will transition to coverage through the exchanges/marketplaces or Medicaid expansion in 2014.

- *Public insurance programs*
  ADAP/Part B funds may also assist clients with premiums and out-of-pocket obligations associated with Medicare Part D and Medicaid. Starting in 2011, the ACA allows ADAP payment of deductibles and co-pays for Medicare Part D clients to count toward the "true out-of-pocket" (TrOOP) threshold, which Medicare Part D beneficiaries are required to meet to move into catastrophic coverage (and out of the coverage gap).[1] Medicare Part D plans are required to coordinate benefits with ADAPs as long as the ADAP participates in the online coordination of benefits process and enters into a data sharing agreement with CMS. ADAP/Part B funds may also be used to assist clients with premium, deductible, and co-pay obligations associated with Medicaid coverage.[2]

HRSA/HAB Policy Notice 07-05 requires that insurance drug formularies at least match the state's ADAP formulary and that the total annual amount spent on insurance not be greater than the annual cost of maintaining the same population on the existing ADAP.[3] As the plans that will be sold through the Marketplaces are identified, ADAP insurance purchasing programs must assess the cost and scope of coverage for each plan to determine the plans for which they will pay ADAP-eligible PLWHA premium and cost-sharing obligations.

Oregon has developed and grown a robust insurance purchasing program, with ninety-nine percent of current ADAP clients enrolled in some form of public or private insurance coverage. Coverage options for clients include: Pre-existing Condition Insurance Plan (PCIP), the state high risk pool, private individual policies, employer group plans, COBRA, Medicaid (if premium/copay is required) and Medicare Part D. ADAP will assume the cost of the client's premium if the plan covers 50% of the cost of the drug or better, without an annual capped benefit, and if the plan formulary is comparable to ADAP's formulary. The program is currently assisting 2,800 clients per month through payment of client premiums, pharmacy co-payments, medical co-payments, and deductibles. ADAP processes premium payments in-house, utilizing batched payments to insurers where possible. Pharmacy co-payments and deductibles are managed through an online PBM secondary adjudication process at the pharmacy administered by Ramsell. Medical co-payment invoices are submitted directly to ADAP from the provider along with an Explanation of Benefits for program payment. Oregon's insurance purchasing program is funded through a mix of ADAP, insurance revenue, and pharmaceutical rebates.

Tennessee started its insurance assistance program over a decade ago in order to provide clients with access to more comprehensive insurance coverage and to reduce program costs. The insurance assistance program helps individuals maintain COBRA coverage, purchase private insurance through HIPAA-guaranteed issue policies, and access coverage through the Preexisting Condition Insurance Plan (PCIP) (it does not provide Medicare Part D assistance). The Tennessee ADAP contracts with a community-based organization, Nashville CARES, to administer the insurance program. Nashville CARES receives a per member/per month administration fee for its services, which covers program costs and personnel. The insurance program is decentralized, meaning that medical case managers from all over the state assist clients in filling out the application and then send it directly to the state through a web-based system. State health department staff review the application to confirm client eligibility and notify Nashville CARES to initiate coverage. Insurance plans are reviewed twice: initially by the medical case manager who will check to ensure the plan adequately covers HIV prescription medications and does not have unreasonable caps on coverage. The plan documents are also submitted to the state for a second review. Policy documents are then sent to Nashville CARES whose staff confirm with insurance plans currency of coverage and the details regarding premiums, and any deductibles and co-pays.

Nashville CARES administers the payment of premiums through arrangements directly with health insurance plans. A separate check is cut for each client and the checks are sent in a batch to each plan on a monthly basis (two months in advance of the coverage month). Nashville CARES also administers payment of client cost-sharing (co-payments and deductibles). ADAP clients enrolled in the insurance assistance program present an identification card at the point of service – whether at a pharmacy or doctor's office – and the provider bills Nashville CARES directly for client cost-sharing obligations. For larger pharmacies that see a greater number of insurance assistance program clients, Nashville CARES will receive a monthly invoice to streamline payments.

Coordination with Private Insurance through Marketplaces

Coordination with federal premium tax credits and cost-sharing obligations

In 2014, the ACA will provide federal subsidies to help people meet premium and cost-sharing obligations as they enroll in private insurance coverage through the Marketplaces. The premium tax credit is available for people with income between 100% and 400% FPL, and the amount of the tax credit will be based on a person's Modified Adjusted Gross Income (MAGI).[4] The premium tax credit is paid in advance (meaning that clients do not have to wait until they file their taxes to receive it) and will be paid directly to the plans. Cost-sharing reductions are also available for people with MAGI between 100% and 250% FPL. The cost-sharing reductions – paid by the federal government directly to the plans – will essentially make the plans more affordable, reducing the amount that the client will have to pay in co-payments and deductibles. See NASTAD's health reform issue brief on the ACA's affordability provisions for more information on the premium tax credits and cost-sharing reductions.

Even with premium tax credits and cost-sharing reductions, ADAP-eligible PLWHA with chronic, complex conditions may still need additional assistance in meeting the unsubsidized portion of premiums and cost-sharing. The role of ADAPs that implement insurance assistance programs in this process will be to:

- Assess plan options for scope of coverage and cost to determine the plans for which ADAP will pay client premium and cost-sharing obligations.
- Develop processes to monitor the amount of premium tax credit support and cost-sharing reductions a potential ADAP client is receiving and the amount that the potential client is expected to pay in premiums and out-of-pocket costs. Processes many include requiring ADAP clients to accept the premium tax credit in advance (as opposed to waiting to receive the credit through an federal tax refund when federal taxes are filed).
- Cover the remaining cost of the premiums and cost-sharing obligations on behalf of the ADAP client, as funding is available and program operations allow.

- In states that do not expand Medicaid, assess the feasibility of purchasing unsubsidized private insurance coverage for ADAP clients with income under 100% FPL who do not qualify for Medicaid under current eligibility rules.
- Consider aligning ADAP income eligibility with MAGI.

Coordinating enrollment and coverage effective dates

Open enrollment for coverage through the Marketplaces begins on October 1, 2013 and the initial open enrollment period runs until March 31, 2014.[5] Once eligibility is determined and a QHP is selected, coverage dates are as follows (these are also the dates on which premium tax credits and cost-sharing reductions would begin):

- If the plan selection is received by the marketplace on or before December 15, 2013, coverage begins January 1, 2014.
- If the plan selection is received by the marketplace between the first and fifteenth day of any subsequent month during the initial open enrollment period, coverage begins the first day of the following month.
- If the plan selection is received by the marketplace between the sixteenth and last day of the month for any month between December 2013 and March 31, coverage begins the first day of the second following month.

NOTE: these are minimum federal standards; states may require earlier effective coverage dates.

ADAPs should coordinate recertification dates with open enrollment dates to ensure a smooth transition to Marketplace coverage. ADAPs should also be prepared to continue to provide prescription drug coverage to clients who may have been determined eligible for federal subsidies and QHP coverage, but whose coverage effective dates have not yet begun.

ADAP Questions and Considerations

As ACA implementation continues, ADAPs should consider the following:

- *Will the ADAP or Part B program put in place an insurance purchasing program or increase the capacity of its existing program in anticipation of client enrollment in Marketplace insurance coverage through the ACA?*
  As states prepare for ACA implementation, many ADAPs are exploring the feasibility of putting in place an insurance assistance program or increasing the capacity of existing programs. This assessment should include coverage of unsubsidized insurance coverage for ADAP clients with income below 100% FPL in states that do not expand Medicaid.

- *Will the ADAP or Part B program pay for deductibles and co-payments in addition to monthly premiums?*
  <u>For insurance continuation:</u> Some ADAPs will provide the payment of all or some combination of insurance premiums, co-pays, or deductibles for clients who have existing insurance policies through their current employment, COBRA, or other supplemental programs.

  <u>For insurance purchasing:</u> ADAPs may provide the payment of the insurance premium, deductible, or co-payment for an ADAP-eligible PLWHA to participate in either the state high-risk insurance pool or private insurance. Some ADAPs cap the amount they will pay to purchase insurance. Providing assistance to ADAP-eligible PLWHAs to help them meet deductible and co-payment obligations may be particularly important as people move into private insurance through the marketplaces. There may continue to be affordability gaps even for people receiving federal cost-sharing subsidies. In addition, in states that do not expand Medicaid, states may purchase QHPs for clients through the Marketplaces; however ADAP-eligible PLWHA with income under 100% FPL, will

be not be eligible for federal subsidies, and ADAPs may want to consider covering ADAP-eligible PLWHA deductible and co-payment obligations.

- *How will insurance be purchased or continued and what relationships and processes should ADAP/Part B programs have in place?*
  Because of the complexity of client tracking and payment processes, the majority of state ADAP/Part B programs contract with a vendor or existing grantee (e.g., a Pharmacy Benefits Manager or AIDS Service Organization) to administer the payment processes for insurance premiums. Other state ADAP/Part B programs handle the client tracking and payment processes internally through their administrative infrastructure. A few state ADAP/Part B programs have a collaborative relationship with another department within their respective Department of Health to process the insurance payments. Overall, the process typically involves verification of client eligibility by the ADAP/Part B, establishment of communication with the insurance company regarding payments made by a third party on behalf of the client, tracking of premium payment due dates and amounts, verification of continuance of the insurance prior to making payment, and the actual payment process of issuing and mailing or transmitting a payment. As marketplaces are implemented, ADAP/Part B programs may want to explore data sharing or other coordination mechanisms with these entities.

- *What procedures does the ADAP/Part B program need to put in place to assess and choose the plans for which it will pay client premiums and cost-sharing obligations?*
  To comply with HRSA requirements around insurance purchasing and continuation, ADAPs/Part B programs will need to assess plans to ensure that the formulary is comparable to the ADAP formulary and to ensure that it is cost effective for the ADAP/Part B program to purchase insurance coverage for clients. For examples of plan assessment tools and procedures, please contact Amy Killelea.

- *How will the ADAP/Part B program ensure that appropriate data is collected on the insurance purchasing program for both the ADAP Data Report (ADR) and ADAP Quarterly Report (AQR)?*
  Insurance services (premiums, co-pays, and deductibles) must be captured in both the ADR and the AQR. If ADAP/Part B programs use ADAP funds to purchase insurance, they should also consider the reporting requirements and ensure that they are able to meet these requirements when reporting.

Insurance Purchasing and Continuation Checklist	
✓	When considering making any changes, determine if they are economically feasible and administratively manageable for the ADAP in light of current staff capacity and internal administrative processes.
✓	Train case managers on how to enroll clients in the insurance program.
✓	Educate clients and case managers about the insurance purchasing and continuation program.
✓	Verify that ADAP pharmacy network or direct purchase administration can work with the health insurance payers.
✓	Consider the feasibility of electronic application systems.
✓	Develop plan assessment tools and procedures.
✓	Anticipate problems with client participation in the insurance program that may occur with implementation and develop procedures to respond rapidly to address unintended consequences – including waivers.
✓	Be familiar with state legislation and administrative regulations that may impact your ability to make changes in ADAP.
✓	Follow the internal state agency process for review and approval of changes to the ADAP.
✓	Communicate to the community about why and when the ADAP will introduce an insurance

	purchasing and/or continuation program.
✓	If Ryan White Part B programs decide to use ADAP funds to purchase health insurance, they must submit a Notification of Intent to HRSA that addresses: the methodology that will be used, an assurance that the pharmaceutical component of the insurance policy includes a formulary equivalent to the ADAP formulary, and assurance that the cost of providing coverage to clients through the insurance program is cost neutral in the aggregate. (See HAB Policy Notice 07-05.)
✓	Consult other ADAPs that have investigated and/or adopted an insurance program to find out how they approached it, the results and lessons learned.
✓	Communicate with your HRSA Project Officer and NASTAD when the state is considering implementing an insurance program, when and if significant challenges arise, and when any changes are actually implemented.

Resources

- National Alliance of State and Territorial AIDS Directors (NASTAD) – www.NASTAD.org
  - NASTAD Health Reform Resources
  - NASTAD, National ADAP Monitoring Project Annual Report Module Two (April 2013) (includes ADAP data template to inform health reform implementation.
- HRSA HIV/AIDS Bureau – www.hab.hrsa.gov
  - ADAP 2012 Manual
  - HRSA/HAB Policies
  - HRSA/ HAB Policy 07-05 (Program Part B ADAP Funds to Purchase Health Insurance)
- HRSA Target Center – Technical Assistance for the Ryan White Community - http://careacttarget.org/
- Kaiser Family Foundation – www.kff.org/hivaids/us.cfm
- Public Law No. 104-191, Health Insurance Portability and Accountability Act of 1996

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[1] HRSA/HAB Letter to Grantees re Medicare Part D True Out-of-Pocket Expenditures for ADAP-eligible PLWHA. November 23, 2010, available at http://hab.hrsa.gov/manageyourgrant/pinspals/adaptroopltr1011.pdf.

[2] HRSA/HAB, Clarifications Regarding Medicaid-Eligible Clients and Coverage of Services by Ryan White HIV/AIDS Program Policy Clarification Notice (PCN) #13-01, available at http://hab.hrsa.gov/manageyourgrant/pinspals/1301pcnmedicaideligible.pdf.

[3] HRSA/HAB, Closing the Gap: Financing Insurance Services with ADAP, available at ftp://ftp.hrsa.gov/hab/report_06_03.pdf.

[4] MAGI is a taxpayer's adjusted gross income with certain additional deductions. MAGI does not include any asset tests or income disregards, which some ADAPs may currently take into account in their income eligibility criteria. See NASTAD, Eligibility Criteria for Medicaid and Insurance Affordability Programs: Modified Adjusted Gross Income (MAGI), available at http://www.nastad.org/Docs/084320_NASTAD%20MAGI%20Definition%20Chart%207.16.12.pdf.

[5] In subsequent years, open enrollment will run from October 15 through December 7 (45 CFR §155.420). Individuals may apply for and enroll in coverage outside of the open enrollment period if a special enrollment period exception applies. Triggering events for special enrollment include:

- A qualified individual or dependent loses minimum essential coverage;
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;
- An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
- A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;
- An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer- sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and
- A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.