



Austin/Travis County Health and Human Services Department

HIV Resources Administration Unit	
Title: Health Insurance Assistance	Policy Number: 0.4
Type: Grant	
Approved: Unit/Program Manager <i>Gregory L. Boldt</i>	Date Approved: March 30, 2016
Attachments:	
<ol style="list-style-type: none"> 1. Texas Department of State Health Services Policy Number 260.002, finalized November 2, 2015, http://www.dshs.state.tx.us/hivstd/policy/policies/260-002.shtm 2. Austin TGA/HSDA Estimated Expenditure on Covered Clinical Services as Benchmark for Cost Comparison 3. Client Eligibility Verification Policy #0.3 4. Client Eligibility Verification Policy Clarification Notice #0.3-0.1 5. Client Eligibility Verification Policy Clarification Notice (PCN) #0.3-0.2 	
Effective Date: April 4, 2016	
Review Date:	Reviewed by:
Review Date:	Reviewed by:

I. PURPOSE:

The purpose of this policy is to:

1. Incorporate by reference the Texas Department of State Health Services (DSHS) Policy Number 260.002;
2. Specify additions, exceptions, and/or clarifications to the DSHS Policy for Ryan White Part A Grant-funded providers of Health Insurance Premium and Cost-Sharing Assistance (Health Insurance Assistance or HIA); and
3. Comply with the Austin Area Comprehensive HIV Planning Council (Planning Council) Directive Number 02-2015.

II. PLANNING COUNCIL DIRECTIVE NUMBER 02-2015:

The Austin Area Comprehensive HIV Planning Council wishes to achieve the following goals for the provision of Health Insurance Premium and Cost Sharing Assistance in order to increase the number of clients who enroll in market place insurance plans:

1. Reduce and ideally eliminate the number of COBRA policies covered by Health Insurance Premium and Cost Sharing Assistance service category.

2. Create a tiered sliding scale system for patient financial contribution in which one tier is 100 to 250% of FPL.
3. Support those in the 100 to 250% FPL tier who have a Silver Marketplace plan by covering 100% of all insurance costs for all services currently being paid for with Ryan White Part A funds including co-pays, deductibles, and premiums.

III. DSHS HIV/STD Program Health Insurance Assistance (HIA) Policy 260.002: HIA Policy Additions, Exceptions and Clarifications

A. 7.2 Service Providers

DSHS HIA Policy exceptions for income eligibility related to local benchmark service costs are provided under F. below.

B. 8.0 Allowable Uses of HIA Funds

Due to limited information on the amount of funding needed in order to comply with the Planning Council's Directive referenced above, HIA funds may not be used in FY 2016 to pay any additional tax liability a client may owe to the IRS based on reconciliation of the premium tax credit. At the discretion of the HIA services provider, HIA clients can be required to sign a Declaration of Responsibility for Additional Tax Liability.

C. 9.0 Estimated Expenditure on Covered Clinical Services as Benchmark for Cost Comparison

Local expenditures on clinical services typically covered by health insurance plans have been benchmarked by DSHS for the Austin area. Current benchmark amounts are shown in Attachment 2. As described in DSHS Policy 270.001, *Calculation of Estimated Expenditures on Covered Clinical Services*, the benchmark amounts are reset annually.

D. 10.0 Allocations for HIA

The Austin TGA Part A Administrative Agency (AA or HRAU) and the Planning Council will confer and collaborate with the area's Part B and State Services Administrative Agency (AA or BVCOG) on maintaining sufficient HIA allocations. Guidance on HIA allocations will continually improve as more information is obtained on the number of presently uninsured clients in the service area who are likely to qualify for low-cost health insurance plans based on client household income as well as on typical levels of client expenditures associated with the Marketplace plans.

E. 11.0 Client Eligibility for HIA Services

To be eligible for HIA services paid for by Part A, individuals must meet the general eligibility criteria described in the HRAU Client Eligibility Verification Policy Number 0.3, Policy Clarification Notice 0.3-0.1, Policy Clarification Notice 0.3-0.2, and the *Austin Transitional Grant Area Eligibility Criteria by Service Category* document updated June 2012.

There are three (3) priority levels of eligibility for HIA services funded by Part A.

1. Clients currently receiving HIA services may continue receiving the same HIA services with existing service limitations, including use of a sliding fee scale as it is

currently being applied. For existing clients on COBRA who are extending job-related coverage after job loss, refer to DSHS HIA Policy item 13.1, COBRA Continuation Coverage.

2. Clients who select Silver Marketplace plans with reduced cost sharing and/or reduced out-of-pocket payments and who are between 100%-250% of the FPL based on the modified adjusted gross income of the household (MAGI) will have 100% of their out-of-pocket expenses for outpatient medical care paid by HIA including premiums, deductibles, co-payments and co-insurance. There are no caps on premium payments for Silver Marketplace plans. Inpatient care and emergency room care are excluded.
3. If additional HIA funds are available, HIA services may be provided to new clients with household incomes >250% of FPL, using a tiered or sliding scale system for determining client financial contribution. A plan for implementing eligibility priority level 3 must be submitted to HRAU for approval.

F. 11.1 Considerations for the Use of Income Eligibility and other Criteria

Based on the Planning Council Directive referenced above, clients who meet the criteria under E. 2. may receive HIA for health insurance plan costs as described. For an individual client, these plan costs may be higher than the local benchmark for the cost of directly delivered services. However, in aggregate, the cost of paying for HIA must be determined to be cost effective versus the Ryan White Program paying the aggregate full cost for medications and other HIV-related outpatient/ambulatory health services.

G. 16.2 Restrictions on Out-of-Network Payments

Payment will not be made for co-payments or co-insurance costs when clients elect to use out-of-network providers or fill prescriptions for drugs that incur higher co-pays or co-insurance because they are outside their health plan's formulary. Exceptions may be made for payments for HIV-related care if an in-network provider is not available or appointment wait time for an in-network provider exceeds standards for delivery of care as documented by the Texas Department of State Health Services and Austin Transitional Grant Area (TGA) Standards of Care for Outpatient Ambulatory Medical Care, the United States Public Health Service's (USPHS) HIV treatment guidelines, or by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional certified to prescribe antiretroviral (ARV) therapy. Documentation for out-of-network payments and payments for drugs that are outside the client's health plan formulary will be placed in the client's file.

IV. HIV-Related Care Documentation

HIV-related care includes all types of care provided by or ordered by the client's HIV primary care provider, including medications. The main characteristic of primary care is that the patients consult their primary care physician for routine check-ups and any time they have a new physical problem. Consequently, primary care practitioners treat patients seeking to maintain optimal health as well as those with acute and chronic physical, mental, and social health issues, including multiple chronic diseases. Chronic illnesses usually treated by primary care providers include: hypertension, heart failure, angina, diabetes, asthma, COPD, depression, anxiety, back pain, arthritis, thyroid dysfunction, and HIV. Primary care is inclusive of HIV-related care and routine primary care unrelated to HIV disease. Where medical specialty care is required, Ryan

White HIV/AIDS Program funding is provided only if the condition is related to the individual's HIV disease. For conditions that are not known to be related to HIV disease, a letter or other documentation such as a waiver establishing HIV-relatedness must be signed by a physician, physician's assistant, clinical nurse specialist, nurse practitioner or other health care professional certified to prescribe antiretroviral (ARV) therapy and placed in the client's file. Documentation should confirm that the medical care and/or medications are necessary in order to ensure positive HIV health outcomes.

V. Revision History

Revision No.	Date	Description of Changes	Completed by

Attachment 2

Austin TGA/HSDA Estimated Expenditure on Covered Clinical Services as Benchmark for Cost Comparison

Austin TGA/HSDA

	Expected Per Client Clinical Expenditure	Average ADAP Cost	Total Direct Expenditure	Average Area Maximum Insurance Cost
Data Source:	Workbook	DSHS Program	Calculated Figure	DSHS Ins. Cost Tables
Under 100% FPL	\$1,615.42	\$5,748	\$7,363.42	\$10,735.35
100% FPL	\$1,615.42	\$5,748	\$7,363.42	\$2,541.33
133% FPL	\$1,615.42	\$5,748	\$7,363.42	\$2,875.56
150% FPL	\$1,615.42	\$5,748	\$7,363.42	\$3,889.37
200% FPL	\$1,615.42	\$5,748	\$7,363.42	\$4,788.81 ¹
250% FPL ¹	\$1,615.42	\$5,748	\$7,363.42	\$4,788.81 ¹
300% FPL	\$1,615.42	\$5,748	\$7,363.42	\$10,735.61
400% FPL	\$1,615.42	\$5,748	\$7,363.42	\$10,735.61

¹ The Average Maximum Insurance Cost for 200%-299% FPL was collected at 250% FPL. The average cost does not differ between 200% and 250% FPL. The increase in cost comes above 250% FPL.